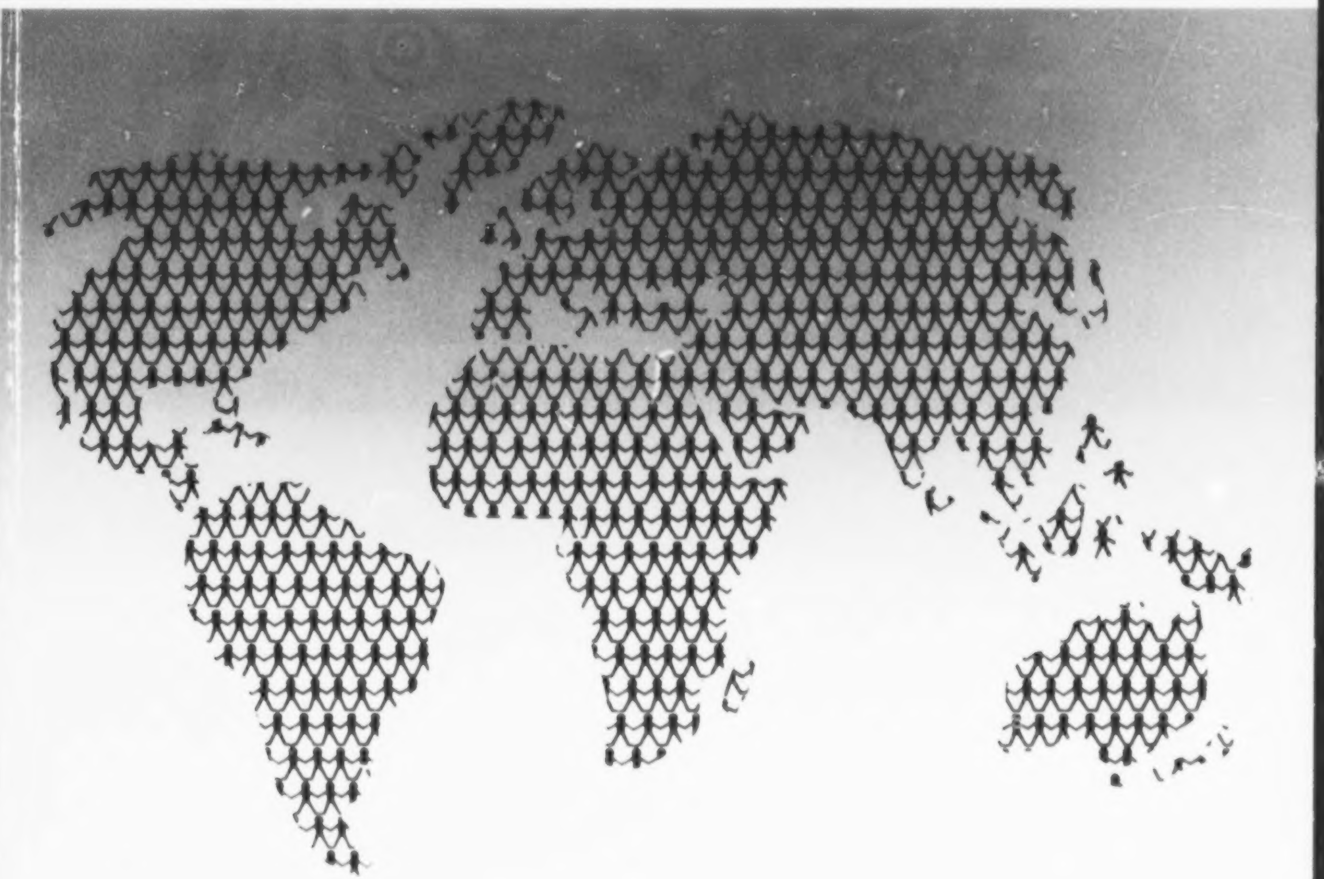
THE STATE OF THE WORLD'S CHILDREN

1993



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(UNICEF)

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THE STATE OF THE WORLD’S CHILDREN

1993

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(UNICEF)

PUBLISHED FOR UNICEF

Oxford University Press

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STATISTICAL NOTE

In this report, the total annual number of child deaths in the developing world is given as 12.9 million. In previous years, the figure of 14 million has been used. This note gives the background to this change.

The under-five mortality rate (U5MR) is the number of children who die before the age of five for every 1,000 live births. It is affected by many factors, including income, nutrition, health care, water supply, and parental education. It is therefore one of the principal indicators used by UNICEF to measure levels of, and changes in, the well-being of children.

Unfortunately, most developing countries have no comprehensive system of registering births and deaths. Estimates of under-five deaths are therefore made by the United Nations Population Division (UNPD) using an indirect approach based on demographic models. The 12.9 million figure is arrived at by this method and is the latest UNPD estimate for 1990.

In parallel with this indirect approach, UNPD and UNICEF are also developing a more direct method of assessing levels and trends in under-five deaths for each country. Drawing on a variety of sources, including population censuses, household surveys, and surveillance studies, the new study brings together available data from 82 countries and is published under the title *Child mortality since the 1960s - a database for developing countries*. For the most populous countries, U5MR trend lines have also been plotted, using standard statistical techniques. The resulting new estimates for U5MR in 1990 have been incorporated into the statistical annex of this report.

The results so far indicate that these improved methods of assessment will yield a new total of approximately 12.7 million under-five deaths each year in the developing world. This is less than, but broadly in line with, the figure of 12.9 million used in the text of this report. This figure may change as new data becomes available and as more countries are assessed by the new method.

The overall trend in the number of under-five deaths in the developing world each year can be summarized as follows:

Year	1960	1970	1980	1990
Per year (millions)	18.9	17.4	14.7	12.7
Per day (thousands)	52	48	40	35

The question remains - is this change a function of better statistics and new methods of analysis, or does it reflect actual improvements in child health and survival?

Unfortunately, there can be no clear-cut answer. For more than half the developing countries, the raw data used to arrive at these new estimates, even if based on direct measurements and even if interpreted by improved statistical analysis, is still data which refers to 1987 or earlier. Although an increasing proportion of countries have data for more recent years, most national estimates for 1990 are still projections of trends from the early and mid-1980s.

Where very recent individual country figures are available, the results are mixed; U5MR appears to have decreased significantly in Egypt, for example, but to have increased in Zambia. For some countries, there is evidence of a deterioration caused by factors ranging from war and drought to debt-induced recession, falling commodity prices, and the impact of AIDS. But it is also known that the immunization achievements of the 1980s are now preventing approximately 3 million deaths a year (and probably many more as immunization also helps protect against malnutrition). Similarly, the spread of ORT is preventing an estimated 1 million dehydration deaths each year.

It is UNICEF's expectation that these positive factors will have outweighed the negative and that the progress made in the last five years, as yet only partially reflected in the statistics, will have reduced the annual number of child deaths to considerably below the figure of 12.9 million a year used in this report.

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I The age of neglect and the age of concern

Despite all the problems of the post cold war world, it is clear that the means are now at hand to end mass malnutrition, preventable disease, and widespread illiteracy among the world's children. Following the 1990 World Summit for Children, many countries have now drawn up specific plans for achieving this goal. An accumulation of reasons suggest that the time is now right to make this attempt. The additional cost would be in the region of $25 billion a year. At the moment, only about 10% of the resources available for development are devoted to such purposes.

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II A common cause

To give this cause priority, a worldwide movement is required to bring to bear the same kind of pressure as is today being exerted by the environmental and women's movements. Protecting today's children from the worst aspects of poverty would strengthen efforts to promote environmental protection, sustainable economic growth, equality for women, population slow-down, and political stability. It is therefore a cause that merits the support of all.

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III A movement for basic needs

Many hundreds of organizations, especially in the developing world, are already beginning to respond to this challenge. In particular, support is needed from the media, from health and education professionals, and from the non-governmental organizations.

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IV The wider context

Political and economic change in the world at large is creating the conditions which, however difficult, offer new hope for overcoming the worst aspects of world poverty. But those who support a movement to meet basic human needs must also be aware that action on debt, trade, aid and loans, and on trading relationships, is a necessary part of that struggle.

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Basic indicators, nutrition, health, education, demographic indicators, economic indicators, women, less populous countries, newly independent countries, the rate of progress.

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I

THE STATE OF THE WORLD'S CHILDREN 1993

James P. Grant

The age of neglect and the age of concern

A common cause

A movement for basic needs

The wider context

THE STATE OF THE WORLD'S CHILDREN 1993

"The necessary task of drawing attention to human needs has unfortunately given rise to the popular impression that the developing world is a stage upon which no light falls and only tragedy is enacted. But the fact is that, for all the set-backs, more progress has been made in the last 50 years than in the previous 2,000. Since the end of the Second World War, average real incomes in the developing world have more than doubled; infant and child death rates have been more than halved; average life expectancy has increased by about a third; the proportion of the developing world's children starting school has risen to more than three quarters; and the percentage of rural families with access to safe water has increased from less than 10% to almost 60%.

"Over that same time, much of the world has also freed itself from colonialism, brought apartheid in all its forms to the edge of extinction, and largely freed itself from the iron grip of fascist and totalitarian regimes.

"In the decade ahead, a clear opportunity exists to make the breakthrough against what might be called the last great obscenity - the needless malnutrition, disease, and illiteracy that still casts a shadow over the lives, and the futures, of the poorest quarter of the world's children."

The State of the World's Children 1993

The age of neglect and the age of concern

Amid all the problems of a world bleeding from continuing wars and environmental wounds, it is nonetheless becoming clear that one of the greatest of all human aspirations is now within reach. Within a decade, it should be possible to bring to an end the age-old evils of child malnutrition, preventable disease, and widespread illiteracy.

As an indication of how close that goal might be, the financial cost can be put at about $25 billion a year.* That is UNICEF's estimate of the extra resources required to put into practice today's low-cost strategies for protecting the world's children. Specifically, it is an estimate of the cost of controlling the major childhood diseases, halving the rate of child malnutrition, bringing clean water and safe sanitation to all communities, making family planning services universally available, and providing almost every child with at least a basic education.[1]

In practice, financial resources are a necessary but not sufficient prerequisite for meeting these basic needs. Sustained political commitment and a great deal of managerial competence are even more important. Yet it is necessary to reduce this challenge to the denominator of dollars in order to dislodge the idea that abolishing the worst aspects of poverty is a task too vast to be attempted or too expensive to be afforded.

To put the figure of $25 billion in perspective, it is considerably less than the amount the Japanese Government has allocated to the building of a new highway from Tokyo to Kobe; it is two to three times as much as the cost of the tunnel soon to be opened between the United Kingdom and France; it is less than the cost of the Ataturk Dam complex now being constructed in eastern Turkey; it is a little more than Hong Kong proposes to spend on a new airport; it is about the same as the support package that the Group of Seven has agreed on in 1992 for Russia alone; and it is significantly less than Europeans will spend this year on wine or Americans on beer[3] (fig. 1).

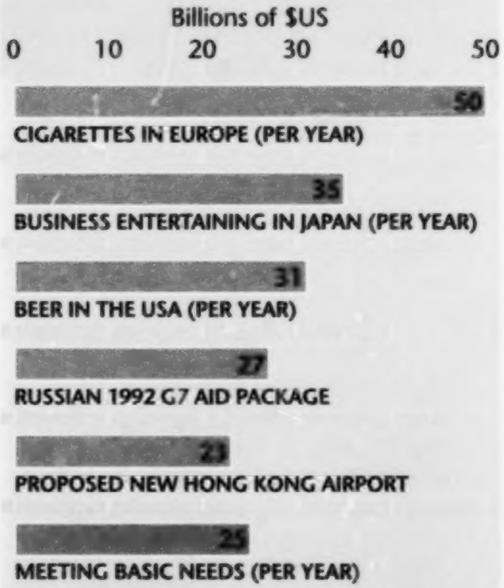
---

* In 1990, UNICEF estimated at $20 billion a year the extra financial resources needed to meet the health, nutrition, education, and water and sanitation goals agreed at the *World Summit for Children*. Estimates for the additional resources required to also meet family planning goals have since become available[2] and this has increased the overall estimate to approximately $25 billion a year.

Whatever the other difficulties may be, the time has therefore come to banish in shame the notion that the world cannot afford to meet the basic needs of almost every man, woman, and child for adequate food, safe water, primary health care, family planning, and a basic education.

Fig.1 Affording the cost

It is no longer possible to say that the task of meeting basic human needs is too vast or expensive a task. With present knowledge, the task could be accomplished within a decade and at a cost of an extra $25 billion per year. Some comparisons:



$25 billion is UNICEF's estimate of the extra resources required to control the major childhood diseases, halve child malnutrition, reduce child deaths by 4 million a year, bring safe water and sanitation to all communities, provide a basic education for all children, and make family planning universally available.

Source: UNICEF, derived from various sources.

A 10% effort

If so much could be achieved for so many at so little cost, then the public in both industrialized and developing countries might legitimately ask why it is not being done.

In part, the answer is the predictable one: meeting the needs of the poorest and the least politically influential has rarely been a priority of governments. Yet the extent of present neglect in the face of present opportunity is a scandal of which the public is largely unaware. On average, the governments of the developing world are today devoting little more than 10% of their budgets to directly meeting the basic needs of their people.[4] More is still being spent on military capacity and on debt servicing than on health and education.[5]

Perhaps more surprising still, less than 10% of all international aid for development is devoted to directly meeting these most obvious of human needs (fig. 2).[6] According to one study, for example, as little as 1.5% of all bilateral aid goes to primary health care, 1.3% to family planning, 3.2% to 'other health care', and only 0.5% to primary education.[7] Because national aid programmes are not broken down into common or comparable categories, such figures can only be approximate; but 10% is probably a generous overall estimate of the proportion of bilateral aid allocated to such purposes.[8] And as total bilateral aid from the Western industrialized nations is approximately $40 billion a year,[9] this means the amount given for nutrition, primary health care, water and sanitation, primary education, and family planning comes to about $4 billion a year. This is less than half as much as the aid-giving nations spend each year on sports shoes.[10]

It could therefore fairly be said that the problem today is not that overcoming the

Fig. 2 Aid for basic needs

The overseas aid given by governments is known as official development assistance (ODA). 80% of this aid is 'bilateral' – given directly from one government to another. The other 20% is 'multilateral' – given through international organizations. The table shows what percentage of bilateral aid is allocated to basic needs related to children – nutrition, water, sanitation, primary health care, primary education, and family planning.

Percentage of bilateral ODA (OECD countries) allocated to meeting basic needs, 1990

	Net bilateral ODA (US$ millions)	Percentage allocated to basic needs	Amount allocated to basic needs (US$ millions)	Amount available for basic needs if 20% allocated (US$ millions)
Norway	756	19.7	149	150
Switzerland	551	18.1	100	110
Finland	498	15.7	78	100
Canada	1690	10.9	184	340
Denmark	695	10.6	74	140
Netherlands	1901	9.4	179	380
UK	1483	8.8	131	300
Italy	2112	8.5	180	420
USA	8370	8.3	695	1670
Austria	299	8.1	24	60
Sweden	1384	7.1	98	280
Belgium	548	6.5*	36	110
Ireland	23	6.5*	1	5
New Zealand	82	6.5*	5	16
France	7829	4	313	1570
Japan	6786	2.7	183	1360
Australia	753	2	15	150
Germany	4479	1.9	85	900
Total	*40239*	*6.3***	*2530*	*8061*

* Figure not available. Average share of 6.5% has been applied.

** Statistical work on the percentage of aid allocated to basic needs is still at a rudimentary stage and there are many problems of definition and international comparability still to be resolved. For this reason, the text of this report uses a figure of 'approximately 10%' as the basic needs portion of aid flows, rather than the more precise figure yielded by this table.

Source: *Human Development Report 1992*, table 3.14, UNDP, New York, 1992. *Development Co-operation*, OECD, Paris, 1991.

worst aspects of world poverty is too vast or too expensive a task; it is that it has not seriously been tried.

A watershed

With the beginning of the 1990s has come new hope that the age of neglect may be giving way to the age of concern.

The evidence for this new hope, amid all the seismic shifts in the political and economic landscape of recent years, is a series of quieter changes which have not made the nightly news but which have affected the daily lives of millions of people.

The first of these changes is the entirely new priority that has been given to the task of immunizing the world's children. For a decade, national health services, UNICEF, the World Health Organization (WHO) and many thousands of individuals and organizations have struggled towards the goal of 80% immunization coverage in the developing world. In 1990, that goal was reached. The result is the saving of over 3 million children's lives each year (fig. 3), and the protection of many millions more from disease, malnutrition, blindness, deafness, and polio. Second, the number of child deaths from diarrhoeal disease has been reduced by over 1 million a year through empowering one third of the developing world's families to use the technique of oral rehydration therapy (panel 5).

The significance of these achievements goes beyond even the extraordinary numbers of lives saved and illnesses prevented. Eighty per cent immunization means that approximately 100 million children are being reached by a modern medical technique on four or five separate occasions during their first year of life. As a logistical achievement, it is unprecedented; and it shows beyond any doubt that the

1

Pneumonia: 3.5 million deaths

Respiratory infections account for more than a quarter of all illnesses and deaths among the children of the developing world. They are also responsible for 30% to 60% of all visits to doctors and clinics and for about a third of all hospital admissions. The toll on both health and health services is enormous; and it is levied on almost every poor country.

In over 90% of cases, the problem is the common cold, for which there is no known cure. But this does not prevent up to one third of the developing world's budgets for drugs and medicines being swallowed up in the prescribing of unnecessary antibiotics. Nor does it prevent families worldwide from spending an estimated $3 billion a year on the more than 2,000 cough and cold remedies now on the market.

Meanwhile, a small minority of respiratory infections, probably only 2% or 3%, strike at the tissue of the child's lung. The result is pneumonia, and without an antibiotic there is a 10% to 20% risk that the child will die within days. But because the victims are usually children from the poorest families, without easy access to doctors and hospitals, antibiotics are often not available at all, or not available in time. The result is that approximately 3.5 million children die each year.

In 80% to 90% of cases, the problem is bacterial pneumonia, which can be controlled by a course of antibiotics, usually cotrimoxazole, lasting for five days and costing 25 cents. But if the scientific problems are relatively simple, the logistical problems are not. How can the right care and the right drugs be made available to the right children at the right time?

In recent years, a clear answer to this question has been tested and found to work. Parents can be educated to recognize the first danger signs, and community health workers can be trained to diagnose pneumonia, prescribe on-the-spot antibiotics, and recognize the small minority of emergency cases that need to be urgently transferred to the nearest hospital.

In many countries, the medical profession is still reluctant to allow health workers to prescribe drugs. But a recent study by WHO has concluded: "*The answer to one question is clear: this strategy ... has been effective. The reduced mortality rates speak for themselves. Studies of ARI (acute respiratory infections) interventions in Bangladesh, India, Indonesia, Nepal, Pakistan, the Philippines and Tanzania show reductions in pneumonia mortality ranging from 25% to 67%.*"

Over 60 developing countries now have national programmes to try to put the new strategy into effect. The aim is to reduce deaths from pneumonia by at least one third in this decade.

In addition, about 20% of acute respiratory infections could still be prevented by immunization. Over a third of a million children die each year from whooping cough, and hundreds of thousands succumb to the pneumonia that frequently follows an attack of measles.* Other known risk factors are low birth weight and malnutrition. Research in Brazil and Peru has shown that the risk increases by between three and five times if children are bottle fed. And from Indonesia has come the finding that risks are doubled by even mild vitamin A deficiency (panel 3). Overcrowding and a smoky environment (including wood smoke and cigarette smoke) also increase the likelihood of respiratory infections.

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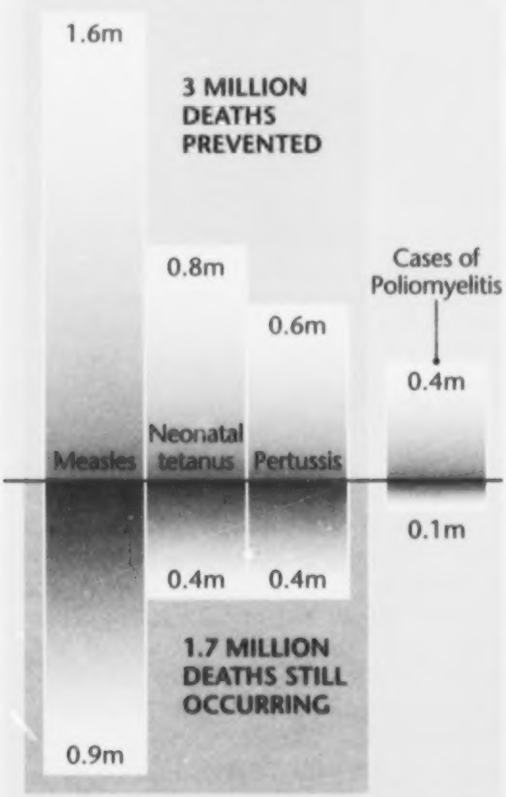
* Measles vaccination, which is normally given at the age of nine months, could not prevent the 50% of pneumonia deaths which occur before that age.

Fig. 3 Three million lives saved

Immunization coverage in the developing world has been increased to approximately 80% in the last 10 years. As a result, three million deaths from vaccine-preventable diseases are now being prevented each year.

Deaths prevented and still occurring, from vaccine-preventable diseases, in millions, all developing countries, 1991



Three million deaths prevented is less than the figure reported in last year's *State of the World's Children* (3.2 million). This is as a result of recent changes in the method used by the World Health Organization for calculating the number of measles deaths prevented by immunization.

Source: WHO and UNICEF, July 1992.

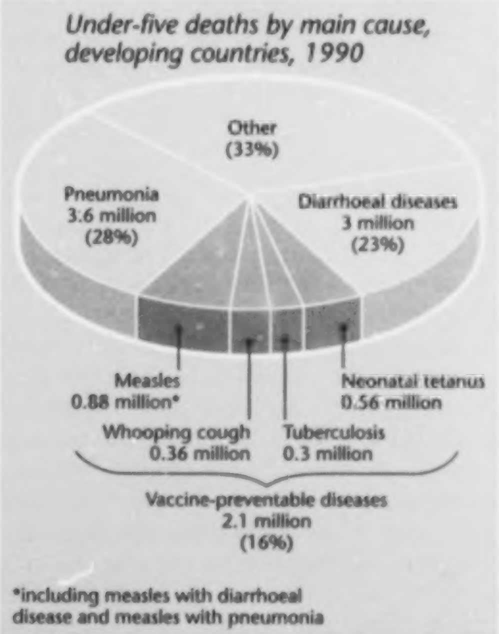
outreach capacity now exists to put the most basic benefits of scientific progress at the disposal of the vast majority of the world's poor. Secondly, it demonstrates that, with sustained political commitment, progress can now be made towards basic social goals even by the poorest of developing countries; over the last five years, immunization coverage has been lifted dramatically in many nations with per capita incomes of less than $500 a year, including Bangladesh, the Central African Republic, Equatorial Guinea, Myanmar, Nepal, the Sudan, Uganda, Viet Nam, and Zambia.[11]

Other advances in knowledge and technique are now lining up outside the door that immunization has unlocked. And the potential remains enormous. Thirty-five thousand children under five die in the developing world every day. Almost 60% of those deaths, and much of the world's illness and malnutrition, are caused by just three diseases - pneumonia, diarrhoea and measles - all of which can now be prevented or treated by means which are tried and tested, available and affordable (figs. 4 and 5 and panels 1 and 5). Similarly, the vitamin A deficiency which threatens up to 10 million of the world's children with death, serious illness, and loss of eyesight, could now be brought under control at a cost which is almost negligible in relation to the benefits it would bring (panel 3).[12] Or to take another example, the iodine deficiencies that lower the mental and physical abilities of up to a billion people and are the world's single biggest cause of mental retardation could also now be eliminated at a total cost of approximately $100 million - less than the cost of two modern fighter planes (panel 10).[13]

Even those aspects of poverty which have traditionally been considered the most expensive and the most logistically stubborn - the lack of adequate nutrition, safe water supply, and basic education - are also now becoming susceptible to a combination of new technologies, falling costs, and community-based strategies. The cost of providing clean water in Africa, for example, has been halved since the mid-1980s and now stands at an average figure of about $20 per person per year.[14] Similarly, countries such as Bangladesh and Colombia have demonstrated that a basic, relevant education can be provided at a cost of approximately $20 per child per year.[15] Equally large-scale trials in Africa and in India have shown that the incidence of child malnutrition can also now be halved at a cost of less than $10 per child per year.[16] "*A direct attack on malnutrition is needed...*" says a World Bank report, "*and governments willing to make that effort now have effective and affordable measures to make it happen.*"

Fig. 4 Child deaths

Over 60% of the 12.9 million child deaths in the world each year are caused by pneumonia, diarrhoeal diseases, or vaccine-preventable diseases, or by some combination of the three.



Under-five deaths by main cause, developing countries, 1990

*including measles with diarrhoeal disease and measles with pneumonia

In practice, children often die from multiple causes or from the interrelated effects of frequent illness and malnutrition. For the purpose of this chart, each child death has been allocated to only one cause.

Source: WHO and UNICEF.

New goals

These advances in technology and strategy, and the extraordinary potential they have revealed, were the principal concern of the *World Summit for Children* held at the United Nations in September 1990 - at about the same time as the immunization goal was being reached. The *Summit* was attended by approximately half the world's Presidents and Prime Ministers and resulted in a set of specific commitments which, if implemented, would indeed mark the beginning of a new era of concern.

Those commitments, designed to reflect the potential of the new knowledge and the new technologies now available, were expressed as a series of specific goals to be achieved by the end of the present century. These goals include: control of the major childhood diseases; a halving of child malnutrition; a one-third reduction in under-five death rates; a halving of maternal mortality rates; safe water and sanitation for all communities; universally available family planning services; and basic education for all children (page 59).

To give these commitments a more permanent purchase on political priority, all the countries represented at the *Summit*, and many more who have subsequently signed the

Declaration and Plan of Action, also agreed to draw up detailed national programmes for reaching the agreed goals. As of September 1992, such plans have been completed in over 50 countries and are nearing completion in more than 80 others (see pages 60 and 61). In June of 1992, the United Nations Secretary-General reported to the General Assembly that 31 countries have so far indicated they will restructure budgets to increase the proportion of government spending devoted to primary education, basic health care, nutrition, water, and sanitation.[17]

Fig. 5 Preventable deaths

The table shows the number of child deaths each year by main cause, and the proportion of those deaths that could now be prevented by relatively simple and inexpensive means such as vaccines, antibiotics, oral rehydration therapy, and the proper management of diarrhoeal disease.

Percentage of under-five deaths preventable by low-cost methods, developing countries, 1990

Cause	Annual number of child deaths (thousands)	Proportion of deaths preventable at low cost (per cent)	Number of deaths preventable at low cost (thousands)
Diarrhoea	3000	90	2700
Pneumonia	3560	70	2492
Measles*	880	85	748
Whooping cough	360	80	288
Neonatal tetanus	560	90	504
Tuberculosis	300	65	195
Malaria	800	70	560
Other peri- & neonatal	2470	25	618
Other	970	–	–
Total	*12900*	*63*	*8105*

* Includes measles with diarrhoeal disease and measles with pneumonia.
In practice, children often die from multiple causes or from the interrelated effects of frequent illness and malnutrition. For the purpose of this chart, each child death has been allocated to only one cause.

Source: WHO and UNICEF.

The drawing up and financing of such plans is inevitably a bureaucratic process, and too much should not be expected too soon. But most nations have made a start towards keeping the promises that have been made to the world's children. Immunization levels have been sustained (fig. 6 and panel 4) and in some cases, notably in China, lifted above the new goal of 90% (at which point very significant decreases in the incidence of disease can be expected). Polio has almost certainly been eradicated from Latin America and the Caribbean (fig. 7 and panel 6), where a year has now passed since the last confirmed case of the virus. Reported cases of the main vaccine-preventable diseases are declining (figs. 7 and 8) and WHO believes there is a reasonable chance that the 1995 goal of eliminating neonatal tetanus will be met. Countries such as Bangladesh, Bolivia, Ecuador, Malawi, Namibia, Sri Lanka, Tanzania, and possibly Brazil have already begun serious efforts to halve the rate of malnutrition. Similarly, several countries are moving determinedly towards the goal of water and sanitation for all - including Bangladesh, Burundi, China, Ghana, India, Nigeria, Paraguay, the Sudan, Togo, Viet Nam, and virtually all the countries of Central America.[18] And to achieve the *Summit* goal of empowering all families with today's knowledge about the importance of breast-feeding, hundreds of hospitals and maternity units have begun to change institutional policies and to use their enormous influence to reverse the trend towards the bottle-feeding of infants (panel 13).

Not least, the promise of the *Summit* is being kept by the rapid spread of acceptance for the *Convention on the Rights of the Child*,

2

Mexico: from words to deeds

Some 50 nations have now drawn up national programmes of action (NPAs) aimed at reaching the targets agreed at the *World Summit for Children*. Those targets, to be reached by the year 2000, include a halving of child malnutrition, control of the major childhood diseases, a one-third reduction in under-five death rates, a halving of maternal mortality, the provision of safe water to all communities, the universal availability of family planning services, and a basic education for all children.

In Latin America, almost all countries have completed NPAs. Mexico, in particular, has made a determined start; a detailed NPA has been drawn up, and its progress is being monitored every six months under the personal chairmanship of President Carlos Salinas de Gortari. The main points:

○ As the debt crisis has eased and the country has returned to economic growth, the deep cuts in social spending of the 1980s are being reversed. As a percentage of GDP, social spending has risen from 6.4% to 9% in the first two years of the 1990s.

○ An ambitious immunization programme has already reached more than 90% of the country's 11 million under-fives. More than 1,000 rural clinics have been built. Approximately 1,300 health centres and 140 hospitals have been refurbished. And specific programmes have been launched to control two of the biggest threats to the life and health of Mexico's children - diarrhoeal disease and acute respiratory infections.

○ To reduce malnutrition, a growth monitoring programme has begun with the aim of reaching all preschool children. Food supplements are beginning to be made available to children from families where low income and lack of food is the main cause of malnutrition (in many cases, the main cause is frequent illness).

○ The baby-friendly hospital initiative (panel 13) has moved ahead rapidly, and 30 maternity units or hospitals have so far been awarded 'baby-friendly' status. The practice of free distribution of commercial infant formulas, common in many countries of the developing world, has been suspended, and a training programme is under way to explain the advantages of breastfeeding to both nursing staff and general public.

○ Following the cuts made in the 1980s, the last four years have seen a 70% increase in the resources earmarked for education. As a result of the new National Agreement on the Modernization of Basic Education, a special effort is being made to reduce educational disparities. In the country's 10 poorest states, support has been provided to 1,000 schools, including 270,000 financial 'scholarships' designed to stop children from dropping out of school because their families are too poor to keep them there. With the support of the World Bank, and the cooperation of UNDP, UNESCO, and UNICEF, the Government has also begun a programme of non-formal initial education for 1.2 million children.

○ Over 1 million copies of *Facts for Life* have been published, and 600,000 are now in use in the educational system. The *Facts for Life* booklet, jointly published by UNICEF, UNESCO, UNFPA and WHO, sets out today's essential child health knowledge on such subjects as: timing births, safe motherhood, breastfeeding, child growth, immunization, diarrhoea, coughs and colds, home hygiene, malaria, AIDS, and child development.

○ A Programme for the Protection of Street Children has begun in Mexico City and in 31 states.

○ Government spending on clean water supplies has more than doubled to over $1 billion, and the number of people served has increased by 8 million since 1990.

which seeks to lay down minimum standards for the survival, protection, and development of all children. The *Convention* was adopted by the General Assembly of the United Nations towards the end of 1989 and came into force, with the necessary 20 ratifications, on the eve of the 1990 *World Summit for Children*. Usually, such conventions require many decades to achieve the stage of widespread international recognition; but in this case, the *Summit* urged all national governments to ratify as quickly as possible and more than 120 have so far done so (see pages 60 and 61).

In some nations, the process of translating the *Convention* into national law has begun. In many nations, it is becoming the accepted standard for what is and is not acceptable in the treatment of the young. In all nations, its mere existence gives citizens, journalists, and non-governmental organizations (NGOs) an agreed platform from which to remind political leaders of their promises and to campaign against the neglect and abuse of children in all its forms (panel 12).

Fig. 6 Sustaining immunization

The goal of 80% immunization by 1990 has been achieved after a determined worldwide effort. Now the question is whether that effort can be sustained. So far, the fall-off has been slight, and many nations have begun the push towards 90% coverage.

Immunization coverage, children under one year, all developing countries, 1981-1991

Year	BCG	DPT3	Polio3	Measles	TT2*
1981	31	27	24	18	14
1984	36	37	36	25	14
1985	40	38	38	28	17
1986	51	49	50	37	19
1987	69	60	60	53	27
1988	75	68	69	60	39
1989	85	77	79	73	44
1990	90	83	85	79	56
1991	85	78	80	77	54

The years 1981 to 1985 exclude data for China
* For pregnant women

Source: WHO and UNICEF, July 1992.

Finally, it is clear that these promises made to the world's children have now established themselves on the international political agenda. Over the last two years virtually every major summit meeting of the world's leaders - the Ibero-American, the Islamic States, the francophone countries, the non-aligned movement, the Commonwealth, the Organization of African Unity, the South Asian Association for Regional Cooperation, the League of Arab States, and finally the United Nations Conference on Environment and Development (panel 9) - has formally confirmed the commitment to achieving the basic social goals that were agreed at the *World Summit for Children*.

Promises on paper

The importance of the *Convention*, the *Summit* goals, and the national programmes of action that have been drawn up should neither be overestimated nor underestimated. At the moment they remain, for the most part, promises on paper. But when, in the mid-1980s, over 100 of the world's political leaders formally accepted the goal of 80% immunization by 1990, that, too, was just a promise on paper. Today, it is a reality in the lives of tens of millions of families around the world.

One lesson to be learned from that achievement is that formal political commitments at the highest levels are necessary if available solutions are to be put into action *on a national scale*. But a second lesson is that such commitments will only be translated into action by the dedication of the professional services; by the mobilization of today's communications capacities; by the widespread support of politicians, press, and public; and by the reliable and sustained support of the international community. Most of the countries that succeeded in reaching the immunization goal, including many that were among the poorest and the hardest hit by problems of debt and economic adjustment,[19] succeeded primarily because large numbers of people and organizations at all levels of national life became seized with the idea that the goal could and should be achieved. Many developing countries could provide examples, but it will be sufficient to cite the case of Bangladesh: against formidable internal and external difficulties, one of Asia's poorest and most populous countries succeeded in lifting its level of immunization coverage from only 2% in 1985 to 62% in 1990. "*Never in the country's history,*" wrote a UNICEF officer in Dhaka, "*had so many groups come together for a single social programme: the President, eight social sector ministries, parliamentarians, senior civil servants, journalists, TV and radio, hundreds of non-governmental organizations, social and youth clubs, religious leaders, film and sports stars and local business leaders all worked successfully towards a common goal.*"[20]

The question for the years immediately ahead is whether people and organizations in all countries and at all levels are prepared to breathe similar life into new goals that have been agreed on, and into the national programmes of action that have been drawn up for achieving them. Only by this degree of popular participation, by the practical and political energies of literally millions of people and thousands of organizations, will the new commitments and the promises of the 1990s be given a priority in national life. And only by such means will a new age of concern be born.

Wider changes

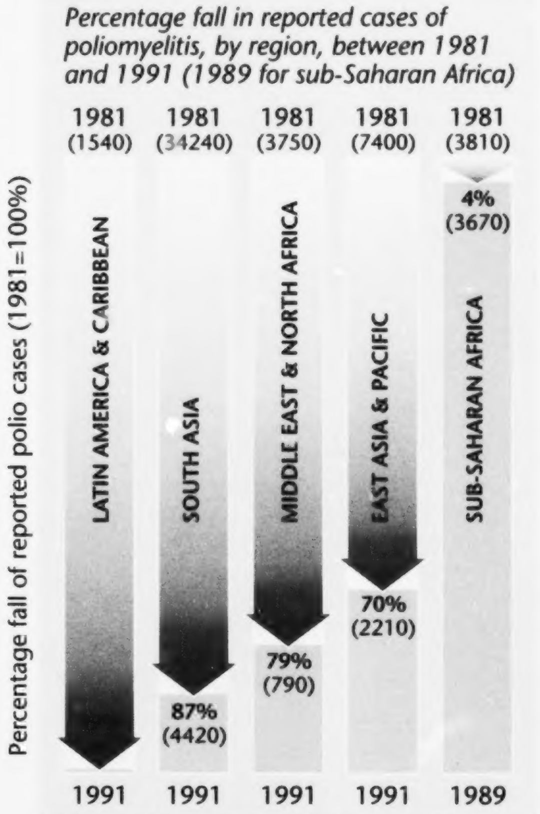
All of these developments, and the hopes to which they have given rise, come at a time of extraordinary change in world affairs. And it is possible to hope that the cause of overcoming the worst aspects of poverty will also draw sustenance, for the long haul ahead, from the changed political and economic environment of the 1990s.

At the moment, that environment remains extremely difficult for most nations of the developing world. There is as yet no sign that the ending of the cold war is leading to any increase in the resources available for development. Indeed, much of the developing world is today facing its worst financial famine of the modern era, starved of resources by its own high levels of military spending, by the continuing debt crisis, by the further falls in commodity prices, by the restrictive trade policies of the industrialized nations, by the lingering recession in large parts of the world, by the costs of post-war reconstruction in the Persian Gulf, and by the channelling of new aid, credit, and investment to the nations of Eastern Europe and the former Soviet Union.

But despite all of these problems, the prospects for progress have been profoundly improved by the enormous political and economic upheavals of recent years: the advance of democracy throughout Latin America; the liberation of Eastern Europe; the collapse of the Soviet Union; the ending of the cold war; the spread of democratic political reform through most of Africa (including the erosion of apartheid); the almost worldwide retreat from the ideology of highly centralized government control over all aspects of economic life; and the growing acceptance of the necessity of joint international action in response to both humanitarian and environmental problems (panel 11).

Fig. 7 Progress on polio

In the 1990s it is essential to monitor not just the level of immunization reached but the impact on the target diseases. The *World Summit for Children* set the goal of eradicating polio by the year 2000. The chart shows that reported cases are on the decline – with Latin America and the Caribbean leading the way.



The figures in parentheses are the absolute numbers of reported cases.

WHO estimates that the actual number of polio cases in 1991 was approximately 100,000 worldwide – almost 10 times the number of reported cases. The relationship between reported cases and actual cases depends on the merits of the surveillance system.

Source: WHO.

These changes amount to one of the most sudden and fundamental transformations in history. And for all the suffering that is surfacing in the turbulent wake of these changes, from Somalia to the former Yugoslavia, it can still be said that this is a transformation which holds out new hope for world development. If the various forms of free-market economic policies now being adopted are not crushed under the weight of military spending, debt repayment, and trade protectionism, then there is real hope of achieving sustained economic growth. And if the steps now being taken towards democracy do not falter under the assault of continued poverty and social unrest, then there is also real hope that the poor will eventually begin to share more equitably in the benefits of that growth.

These developments are changing the overall environment in which the developing world must earn its living and within which its people must struggle to meet their own needs. Whether those needs are met or not depends, first of all, on whether families have jobs and incomes. Second, it depends on whether governments fulfil their responsibilities for providing the essential services and safety nets to support families so that even the most disadvantaged do not suffer from preventable malnutrition, from disease borne by unsafe water and sanitation, or from the lack of even basic health care and education. The great changes of the last five years by no means make such progress inevitable or automatic; but they do make it more possible and more likely.

This coming together of both general and specific developments means that a new threshold in the struggle to overcome the worst aspects of poverty has been reached in the early years of the 1990s. Broad-scale political and economic change is creating an

Vitamin A: suspicion confirmed

3

The 1986 *State of the World's Children* report drew attention to a startling new proposal for protecting the lives and the health of many millions of children. New research in Indonesia had indicated that the lack of vitamin A might be responsible for a large proportion of illnesses and deaths among the under-fives. The findings of the study were summed up by the principal investigator, Dr Alfred Sommer:

"*We know that five to ten million children develop mild xerophthalmia, hence vitamin A deficiency, every year. Given these figures, and the increased risk of death among children with mild, and probably even with subclinical vitamin A deficiency, it may account for as much as 20-30 per cent of all pre-school-age deaths in developing countries.*"

It had long been known that a quarter of a million children were going blind each year from the lack of this particular vitamin. But since the announcement of the controversial findings from Indonesia, other investigations in other parts of the world have sought to expose the deeper relationship between vitamin A and the health and survival of young children. "*If the findings are confirmed,*" said a 1990 report by the Commission on Health Research, "*the strategic implications would be astounding.*"

Early in 1992, 30 experts and researchers met in Bellagio, Italy, to consider all the studies undertaken so far and to pull together conclusions.

Overall, the group confirmed that even mild vitamin A deficiency substantially increases the death rate among children between the age of six months and six years. In particular, vitamin A deficiency significantly increases the severity and risk of the three main health threats facing children in the developing world - diarrhoeal diseases, measles, and pneumonia. It was also confirmed that these findings hold good even when the lack of vitamin A is so mild that it does not show up in the eyesight problems which until now have been the accepted indicator of vitamin A deficiency. "*Therefore,*" says the group's report, "*the definition of vitamin A deficiency for public health purposes must be revised and made more sensitive to milder degrees of deficiency.*"

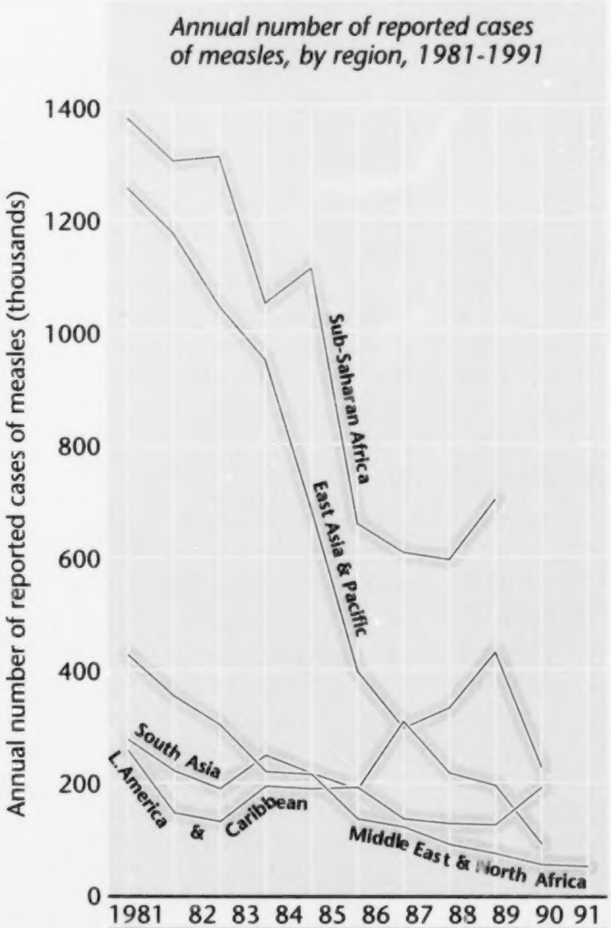
Turning to the question of whether giving vitamin A supplements to children can reverse the risks, the Bellagio group considered the results of six separate investigations in the last decade - two each in India, Indonesia, and Nepal. The studies, involving a total of more than 100,000 children, confirm that giving children extra vitamin A can reduce child deaths by about one third in many areas of the developing world.

There are three main ways of tackling the problem. Parents can be educated about the importance of vitamin A in their children's diet (plenty of green leafy vegetables). Or foods that everybody eats - such as sugar or salt - can have vitamin A added to them at the point of processing. Or vitamin A capsules can be given every six months to young children at risk. All of these strategies are inexpensive. Vitamin A capsules, for example, cost as little as 5 cents each. And with vaccines now regularly reaching over 80% of the world's infants, it should be possible to add vitamin A to immunization services.

There is no longer any reason to wait. Vitamin A supplements have taken their place alongside the handful of other low-cost strategies that could now significantly reduce illness and death among the children of the developing world.

Fig. 8 Progress on measles

The *World Summit for Children* set the goal of a 90% reduction in measles cases (and a 95% reduction in deaths) by the year 2000 – compared with pre-immunization levels. The number of reported measles cases is now declining in all regions, with East Asia showing the steepest fall.



The relationship between reported cases and actual cases depends on the merits of the surveillance system. This system is weakest in Africa, where the number of reported cases should be considered as only broadly indicative.

Source: WHO.

environment more conducive to a renewal of progress against poverty; and advances in technology, in strategy, and in political commitment to meeting basic social goals have given that challenge both a specific focus and a new impetus.

Symptom and cause

If there is one area of the development process that is more widely misunderstood than any other it is the relationship between these two factors - between the long-term processes of overall development and the specific, deliberate, targeted interventions such as are represented by the basic social goals that have been agreed. And it is the nature of this relationship which should also give a new urgency to meeting essential human needs.

With sufficient public and political support, it is clearly now possible to control those aspects of poverty that bring the greatest suffering to the greatest number. In particular, it is possible to close some of the most obvious, the most shameful, and the most damaging gaps between today's knowledge and today's needs.

Closing these gaps will not solve the problems of economic development; it will not remove the burden of debt or restructure inequitable economic relationships; it will not bring an end to oppression and exploitation or eradicate the many causes of unemployment and low incomes; nor will it meet the legitimate aspirations of hundreds of millions of people in the developing world who are not living in absolute poverty but who do not enjoy the amenities of life that are taken for granted in the industrialized nations. It has therefore sometimes been argued that such specific, targeted interventions address only the symptoms of poverty and leave the causes undisturbed.

This is an argument which is no longer deserving of the politeness extended to it in the past.

It is an unacceptable argument on two counts. First, it is an inhuman argument. How much longer must the poorest families wait before it is decided that the world has reached the level of socio-economic development at which a few dollars per capita can be afforded to help them prevent millions of their children from becoming malnourished, blinded, crippled, mentally retarded?

Second, it fails to recognize that frequent illness, malnutrition, poor growth and illiteracy are some of the most fundamental *causes* as well as some of the most severe symptoms of poverty. It fails to take into account that the pulse of economic development is weakened when millions of children suffer from poor mental and physical growth; that the march toward equality of opportunity is slowed when the children of the very poor drop out of school and into a lifetime of illiteracy; that the productivity of communities is enervated by hours spent carrying water from unsafe sources and by the time, energy, and health that is lost to the diseases it brings; that the prospects of finding a job and earning an income are crushed by preventable disabilities such as polio or nutritional blindness; that a family's capacity to save and invest in the future is the less when a child is born mentally retarded by iodine deficiency; and that the contribution of women to economic development cannot be liberated if women remain chained to long years of child-bearing, long days of attendance on illness, and long hours devoted to the fetching and carrying of water and fuel.

In these and many other ways, the worst symptoms of poverty help to crush the potential of the poor, to reduce their control over circumstance, to narrow the choices available to them, and to undermine the long-term process of development.

The struggle for social justice and economic development, both within and between nations, must continue - just as the poor themselves will continue to struggle, as they have always done, to meet most of their own needs by their own efforts. But it is a tragic mistake not to recognize that those efforts can be enhanced by reductions in disease, disability, malnutrition, illiteracy, and drudgery. Today's advances in knowledge and technology could therefore augment future prospects as surely as they could diminish present suffering. And the argument that making today's advances widely available is dealing only with symptoms is an argument as destructive to the future as it is insensitive to the present.

The vulnerable years

These links between poverty's causes and effects lend special weight to the case for doing what could now be done to protect young children from the worst aspects of poverty.

There are many external causes of that poverty. And the process of development must address all of those causes, whether they be rooted in accidental geographical circumstances or exploitative economic relationships. But one of the most intractable of those causes is the fact that the children of the poor do not usually receive the kind of start in life which will enable them to take advantage of the opportunities that do become available. And one of the main aims of development must be to break into this insidious 'inner cycle' of malnutrition and disease leading to poor mental and physical growth; leading to poor performance at school and at work; leading to reduced adult capacity for earning an income, initiating change, responding to new opportunities; leading to poor and often large families which are vulnerable to the malnutrition and disease that close the cycle and allow the current of poverty to flow from one generation to the next.

The place at which to make that break is before the child is born and during the early years of his or her life. *If* the mental and physical growth of the child can be afforded special protection at this time, *if* families and communities and governments can prevent the worst aspects of poverty from affecting the child's normal growth and development, *if* special measures can be taken to give those vulnerable months and years something of the protection which is given to children fortunate enough to be born into a higher socio-economic class, then a major contribution to the breaking of the cycle will have been made.

This is the kind of protection for the vulnerable years which millions of parents the world over make sacrifices to provide. From the point of view of those parents, it is special protection given from love and common sense. From the point of view of the effects of poverty on growth and development, it is special protection given in order to artificially and temporarily lift a child to a higher socio-economic level, for the vulnerable early years, so that the poverty into which that child is born will not, as far as is possible, inflict long term damage.

To illustrate the thesis still further, this is also the kind of special protection that nature itself tries to provide to those vulnerable years in the form of breastmilk. In almost all circumstances, breastmilk means that during the first six months of life a child is well nourished whether he or she is born into the meanest slum or the most opulent mansion. Nature, too, is here attempting to neutralize the fortunes of birth by providing a standard of nutrition that does not reflect, and is not affected by, the socio-economic level of the family into which that child is born.

The capacity for extending this special protection, and for protecting the period of most rapid physical and mental growth from the most damaging aspects of poverty, has now been vastly increased by advances in knowledge and communications capacity. By such means as immunization, growth monitoring and promotion,[21] the proper management of diarrhoeal diseases and respiratory infections, supplementing vitamin A and iodine, targeted food subsidies, and low-cost water and sanitation services, it is now possible to broaden and strengthen this basic protection for the most vulnerable years of life. With today's knowledge and communications power, families, governments, and the international community could now build a shield of basic protection around the early years for *all children*. And in so doing, a major contribution could be made not only to meeting immediate human needs but to breaking the 'inner cycle' of poverty and underdevelopment.

The present opportunity to meet the most basic and obvious needs of children in the poorest quarter of the world must therefore also be seen in the context of this profound relationship between the physical and mental needs of children and the social and economic development of their societies. "*I think it is time,*" says Professor Muhammad Yunus, founder of Bangladesh's Grameen Bank Movement, "*to come out boldly to insist that children should be placed at the centre stage in all development thinking.*"[22]

4

Immunization: sustaining success

By September 1991, the World Health Organization and UNICEF were able to report to the UN Secretary-General that the goal of immunizing 80% of the world's children had been achieved. The result of this decade-long effort, involving many thousands of individuals and organizations worldwide, is that over 3 million child deaths and over 400,000 cases of paralytic polio are now being prevented each year.

The intense drive to reach the goal by the end of 1990 led many to question whether such an effort was sustainable and whether it would distract from the task of building more comprehensive systems of primary health care. Two years after the achievement of the goal, it is possible to begin answering those questions.

Some fall-off from the unprecedented levels of immunization achieved by the target date - the end of 1990 - was to be expected. But the figures for the end of 1991 show that the fall has been slight - approximately 3% in the developing world as a whole. One hundred and one developing countries maintained or increased immunization levels in 1991, and 28 countries recorded a fall in coverage.

In Asia, there has been little or no fall-off. Bangladesh has overcome enormous odds in raising immunization coverage from almost zero in 1980 to 62% in 1990 and has maintained coverage at 60% in 1991 despite every conceivable difficulty. Even Viet Nam, which has had difficulties in obtaining enough vaccine, was able to maintain coverage.

In the Middle East and North Africa, almost all countries have sustained their levels of immunization coverage despite the disruption caused by the Gulf War.

In the Americas, coverage has remained stable with the important exceptions of Brazil and Venezuela, which recorded lower immunization rates in 1991 than in 1990. Nonetheless, the polio eradication campaign in the region is on the verge of victory, with not a single case of paralytic polio being recorded in the last 12 months.

It is in sub-Saharan Africa that the steepest decline has occurred. Overall, the immunization level fell by approximately 10% in 1991, with coverage falling below 50% for polio, measles, and DPT. Most of this decline is accounted for by the 1991 figures from Cameroon, the Central African Republic, Ethiopia, Ghana, Mozambique, Nigeria, and Sierra Leone, where health systems are generally weaker or have been disrupted by social and political unrest. Countries with stronger health systems such as Botswana, Burundi, Cape Verde, the Gambia, Namibia and Rwanda have maintained high levels of coverage and are witnessing dramatic declines in the incidence of disease.

As important as the achievement of the immunization target itself is the setting-up of an outreach system capable of delivering vaccines to over 100 million children on four or five separate occasions in their first year of life. In most countries, that system is now being used for other essential services. In Asia, in particular, the immunization network is being used to combat diarrhoeal diseases (panel 5), acute respiratory infections (panel 1), and vitamin A deficiency (panel 3). India is using the system for its safe motherhood initiative (panel 14), and Bangladesh has begun using immunization outreach services to strengthen family planning services.

Rather than waiting behind clinic doors to serve a minority, many health services have been inspired by the idea of using all available means to reach out into the community to establish regular, ordered contact with an entire population. In the long run, that may prove to be the most fundamental change brought about by the immunization effort of the 1980s.

Outreach capacity

To these arguments must be added two other reasons which add weight to the idea that the time is now right for a decisive advance against the worst aspects of poverty.

One of the most important common factors uniting today's means of protecting lives and health and growth is that almost all of them are able to be put at the disposal of families by a community health worker with only a few months of training. A well-trained, well-supervised, and well-supported community health worker can, for example, help to provide family planning information and services; advise on prenatal care and safe birth practices; inform families of the advantages of breastfeeding; organize immunization and record-keeping services; diagnose acute respiratory infections and prescribe antibiotics; teach oral rehydration therapy and the proper management of diarrhoeal diseases; promote home hygiene and disease prevention; organize growth monitoring sessions; promote today's knowledge about the special feeding needs of the young child; organize protection against malaria; distribute the most essential drugs and medicines; provide vitamin A, iodine, and iron supplements where necessary; and refer more difficult health problems to more qualified health professionals. In short, they can demystify today's basic health knowledge and put it at the disposal of communities. And if they are supported in that task by the full range of today's communications capacities, schools and teachers, religious leaders and local government officials, the print and electronic media, retail outlets and professional organizations, NGOs and women's groups, then the trained health worker can be the central span of the bridge between present knowledge and present need.

There are many problems involved in the deployment of large numbers of community health workers - in their recruitment and retention, in their career structure and motivation, in their regular training and supervision, and especially in the organization of the essential referral services. But such problems can be and have been overcome when the political commitment has been sustained and when the financial resources have been made available.[23]

Above all, it can no longer be claimed that putting a trained health care worker within reach of every family is not a practical and affordable proposition. Assuming a ratio of one health worker for every 200 families, for example, it would require approximately 2 million such health workers to serve the world's poorest 2 billion people (it is not possible, in practice, to reach only the poorest 20%). At an average cost of approximately $1,000 per year, to cover salaries and regular in-service retraining, the total cost would be in the region of $2 billion dollars a year. Such a sum represents approximately 2% of the amount the developing world now spends every year on the salaries of its soldiers.[24]

For a wider range of services, the point has been elaborated by Amartya Sen, Lamont University Professor at Harvard and former Drummond Professor of Political Economy at the University of Oxford:

> "*The question must also be raised ... as to whether a poor country should have to wait many decades before it has enough resources generated by economic growth to undertake ambitious public programmes of health care and education. It is not illegitimate to wonder whether a poor country can 'afford' to spend so much on health and education.*
>
> "*In answering this question we must not only note the empirical reality that many poor coun-*

tries - such as Sri Lanka, China, Costa Rica, the Indian state of Kerala, and others - have done precisely that with much success, but also understand the general fact that delivering public health care and basic educational facilities is enormously cheaper in a poor country than in a rich one. This is because both health and education are labour-intensive activities and this makes them much cheaper in poor countries because of lower wages. Thus, even though a poor country is tremendously constrained in expending money on health and education because of general poverty, the money needed to pay for these services is also significantly less when a country is still quite poor."[25]

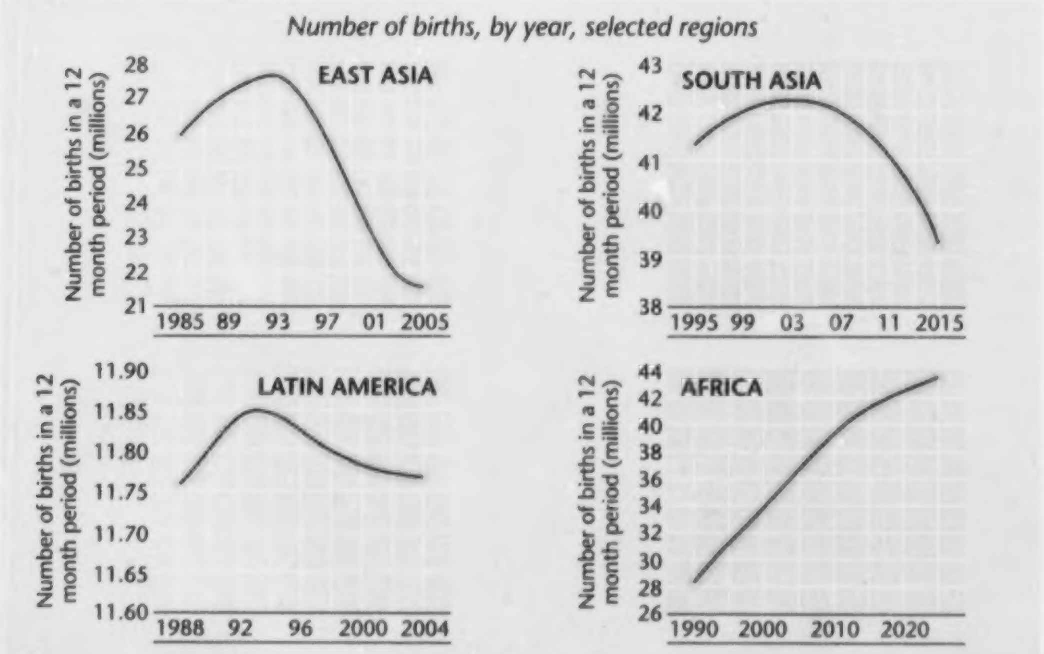
Demographic change

Lastly, the great demographic change taking place in our times also adds it weight to the idea that the time is now right for a determined effort to overcome the worst aspects of poverty.

Fertility rates have fallen in almost every region of the world. In Latin America, the annual number of births has now begun to

Fig. 9 Births peaking

When the annual number of births begins to decline, further investment in health and education can be used to improve the quality of services and increase the *proportion* of people reached. All regions of the developing world, except Africa, are now at or near that point. In Africa, the rate of increase begins to slow only in 2010.



Interpolated from *World Population Prospects* data.

Source: *World Population Prospects 1992*, United Nations Population Division, New York.

decline; in Asia, births will reach a peak in the mid-1990s and begin to fall; even in South Asia, a peak will be reached within a decade (fig. 9). Only in Africa will the annual number of births continue to rise until well into the next century.[26] A turning-point in the modern era will therefore soon be reached. For once the annual number of births is stable or declining, any further investment in such services as health and education can be used to improve the quality of the services offered and to increase the proportion of people reached. In other words, the task of providing such services will no longer be a case of 'running to stand still', and the goal of meeting basic human needs will no longer be a target that is for ever moving away.

Twenty per cent for basics

As the end of the 20th century approaches, there is therefore an accumulation of reasons for believing that ending the worst aspects of poverty is an idea whose time may finally have come.

New strategies and low-cost technologies are available. Specific goals which reflect this potential have been agreed upon. The commitment to those goals bears the signatures of more Presidents and Prime Ministers than any other document in history. The plans for achieving them have been or are being drawn up in most nations. And there is a growing acceptance of the idea that targeting some of these worst effects of poverty, particularly as they affect children, is an essential part of long-term development strategy.

In the wider world, the ground being gained by democratic systems means that the long-starved concerns of the poor may begin to put on political weight; providing basic social services for poor families with the vote is, after all, good politics. At the same time, economic reforms may also create the kind of environment in which a new effort to meet basic human needs would have a much greater chance of success. Meanwhile, the powerful tide of demographic change is also beginning to turn.

For all of these reasons, a new potential now exists for moving towards a world in which the basic human needs of almost every man, woman and child are met. But it is equally clear that this attempt will not gather the necessary momentum unless the political commitment is sustained and the extra resources begin to be made available.

If advantage is to be taken of the political commitments that have been made, and of the national programmes of action that have been drawn up, then those extra resources must begin to become available in the next 12 months to two years.

Some nations have already begun the process of finding the necessary funds from their own resources. In most cases, this is almost certainly going to mean an increase in the proportion of government expenditures allocated to nutrition, primary health care, clean water, safe sanitation, basic education, and family planning services. UNICEF strongly supports the United Nations Development Programme's suggestion that at least 20% of government spending should be allocated to these direct methods of meeting priority human needs.[27] If implemented, such a restructuring of government budgets would enable the developing nations as a whole to find several times the $25 billion a year that is needed to achieve the agreed goals.

In practice, such a shift in present patterns of resource allocation will not be easy to bring about. All governments, however well-intentioned, have limited room for manoeuvre as political pressures push them against the walls of economic constraint. Currently, the governments of the developing world as a whole are spending over one third of their combined budgets on the repayment of debt and on the financing of the military.[28] Such distortions do not happen by accident. And the internal and external forces which have shaped such spending patterns will not disappear overnight. Nor will the pressure to devote disproportionate amounts of public resources to more advanced and more expensive health and education services for the wealthier and more influential sections of society.

But even in the face of all such pressures, it should be possible to allocate 20% of government spending to the task of helping the poor meet their needs for food, water, sanitation, basic health care, family planning, and the education of their children.

Restructuring aid

There remains the question of whether the industrialized nations are prepared to assist in this effort. Following the commitment made at the *World Summit for Children*, every developing country which draws up a detailed programme of action for reaching the agreed goals - no matter what label is attached to the process - should now be able to expect that some proportion of the cost will be met by increased or reallocated aid. That proportion will vary from less than a quarter in East Asia and Latin America, to between a quarter and a half in South Asia, and up to two thirds in the least developed countries and sub-Saharan Africa. For the developing world as a whole, the additional external assistance required will be in the region of an additional $8 billion a year.

So far there is no significant sign that the industrialized nations will make additional resources available on this scale. Aid continues to stagnate. And there have been few serious attempts to restructure existing aid allocations. Government-to-government assistance cannot easily shuffle off the coil of foreign policy considerations, economic vested interests, and historical associations, which means that the richest 40% of the developing world's population receives twice as much aid per head as the poorest 40%,[29] and that the nations which account for two thirds of the world's child deaths receive only one quarter of the world's aid. More positively, it would be a mistake to imply that all the aid not used for directly meeting basic human needs is irrelevant to this cause. Roads also help to meet basic needs. Jobs even more so.

But again, it is not too much to expect that 20% of development aid should be allocated to directly helping people to meet their most basic needs for food, water, health care, family planning and primary education. Such a restructuring of aid expenditures would, on its own, make available the extra $8 billion a year required. It would be an increase in the kind of aid that the majority of people in the developing world want to receive, and in the kind of aid that the majority of people in the industrialized world want to give. And it is an increase which should now be offered to any developing country that commits itself to a programme of action to meet basic human needs.

The same commitment must also be expected from the multilateral organizations which currently disburse approximately $12 billion a year. In particular, the United Nations could play an increasingly central role in international efforts to achieve agreed social goals and to lay a new foundation for human development in the 21st century. And it is a role that could also provide a focus for the impending reform of the United Nations system and lead to the kind of changes which would make sense to, and meet with the approval of, a worldwide public.

The fading excuse

Above all, this is an opportunity that must not be allowed to evaporate into the perennial atmosphere of pessimism about the prospects for world development. The necessary task of drawing attention to human needs has unfortunately given rise to the popular impression that the developing world is a stage upon which no light falls and only tragedy is enacted. But the fact is that, for all the set-backs, more progress has been made in the last 50 years than in the previous 2,000. Since the end of the Second World War, average real incomes in the developing world have more than doubled; infant and child death rates have been more than halved; average life expectancy has increased by about a third; the proportion of the developing world's children starting school has risen from less than half to more than three quarters (despite a doubling of population); and the percentage of rural families with access to safe water has risen from less than 10% to almost 60%. Yet even these extraordinary statistics cannot capture the true dimensions of the change that has occurred in only a few decades. Much of the world has also freed itself from colonialism, brought apartheid in all its forms to the edge of extinction, and largely freed itself from the iron grip of fascist and totalitarian regimes. And underlying all of these changes is the slow and even more fundamental change from a world organized almost exclusively for the benefit of a privileged 10% or 20%, in almost all societies, to a world in which the needs and the rights of all people are increasingly recognized. Only a few decades ago, it did not seem a matter of great concern that the poor majority had no right to vote, no freedom of expression or religion, no right to due process of law, or that their children were not educated or immunized and received little or no benefit from advances in hygiene and health care. In many nations, it even seemed natural that the children of the poor could be sold or bonded or made to work 14 hours a day in field or mine or factory. And almost exactly 50 years ago, when more than a million people starved in the Bengal famine, they died in a world which raised no murmur of protest.[30]

Seen from this longer perspective, the fact that two thirds of the world's people now have the right to vote, or that 80% of the world's infants are immunized, or that there is such a thing as a worldwide *Convention on the Rights of the Child*, is a symptom of a remarkable change. And in the face of such progress, pessimism is a sign less of sagacity than of cynicism. In the decade ahead, a clear opportunity exists to make the breakthrough against what might be called the last great obscenity - the needless malnutrition, disease, and illiteracy that still casts a shadow over the lives, and the futures, of the poorest quarter of the world's children.

It is almost unthinkable that the opportunity to reach these basic social goals should be missed because the political commitment is lacking or because the developing world and the donor nations cannot, together, find an extra $25 billion a year. The technologies and strategies are available and affordable. The outreach and communications capacity are there to be mobilized. The political commitments have been made. And the broader context of political, economic, and demographic

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Diarrhoeal diseases: a strategy for the '90s

Ten years ago, diarrhoeal disease was the biggest killer of the world's children, claiming almost 4 million young lives each year. Most of the victims died of dehydration. And although a cheap and simple method of preventing and treating dehydration had been available for many years, it was known to few outside the scientific community.

Today, thanks to a decade of promotion, some form of oral rehydration therapy (ORT) is known and used by approximately one family in three in the developing world. The result is the saving of approximately 1 million lives each year and the demotion of diarrhoeal disease to second place among the causes of child death.

This success in the last decade has reshaped the challenge for the next. ORT still needs to be promoted; a majority of the developing world's families still do not use the technique; and dehydration still causes over 1.5 million deaths a year. But it is becoming more and more clear that the campaign against diarrhoeal diseases must now be broadened.

The rapid reduction in dehydration deaths brought about by ORT means that an increasing proportion of the remaining deaths are caused by dysentery and persistent diarrhoea, which normally require appropriate antibiotic treatment in addition to ORT. Ten years ago, two thirds of all diarrhoea-related deaths were caused by dehydration; today that proportion has fallen to less than half. At the same time there is a growing realization that diarrhoeal disease is also a major cause - perhaps even the major cause - of malnutrition among the developing world's children. Study after study has shown that frequent diarrhoeal disease stunts the child's normal growth by reducing the appetite, inhibiting the absorption of food, burning up calories in fever, and draining away nutrients from the body.

A strategy for the 1990s must therefore give new priority to clean water and safe sanitation and to educating parents about preventing diarrhoeal diseases and minimizing the impact on their children's health and growth. Today's knowledge makes prevention possible on a large scale and at a low cost. The principal means are: breastfeeding; immunizing against measles; using a latrine; keeping food and water clean; and washing hands before touching food. The main ways of preventing diarrhoea from causing malnutrition are continued feeding throughout the illness (especially breastfeeding) and giving the child an extra meal a day for at least a week after the illness is over. In addition to knowing about the importance of food and fluids, all parents should know that trained help is needed if there is blood in the child's stool or if the diarrhoea persists or is more serious than usual.

Reducing child deaths by one third and child malnutrition by half were two of the most important targets agreed on by the world's leaders at the 1990 *World Summit for Children*. Neither target can be achieved without a widening of the battle against diarrhoeal diseases and a reduction in the toll they take on both the lives and the normal growth of many millions of the world's children.

change is probably as favourable at this time as it is ever likely to be. The difficulties are enormous. But they shrink beside the difficulties that can be and have been overcome in the course of all the many great achievements of our times.

In the industrialized world, neither recession nor competing claims on resources can justify the failure to find the extra $8 billion a year which would be required to support the developing nations that decide to make meeting basic social goals into a national priority.

In the developing world, underdevelopment is a fast-fading excuse for failure to make that commitment and to begin mobilizing the necessary financial and human resources.

It is time that the challenge replaced excuse. If today's obvious and affordable steps are not taken to protect the lives and the health and the normal growth of many millions of young children, then this will have less to do with the lack of economic capacity than with the fact that the children concerned are almost exclusively the sons and daughters of the poor - of those who lack not only purchasing power but also political influence and media attention. And if the resources are not to be made available, if the overcoming of the worst aspects of poverty, malnutrition, illiteracy and disease is not to be achieved in the years ahead, then let it now be clear that this is not because it is not a possibility but because it is not a priority.

6

Polio: the end in sight

On 5 September 1991, laboratory analysis confirmed that Luis Tenorio Cortez, a two-year-old boy from the municipality of Pichanaqui in south central Peru, had been paralysed by type 1 polio virus. Since then, no further cases of polio have been recorded anywhere in the western hemisphere.

Several more years of vigilance lie ahead. But victory is clearly in sight for the Pan American Health Organization (PAHO), which has led the fight to eradicate polio from the Americas.

In the other half of the globe, the virus still paralyses the limbs of over 100,000 children each year. Tragic as this figure is, it still represents remarkable progress. A decade ago, the virus claimed over half a million victims a year. Today, polio vaccine has reached 85% of children worldwide. In some countries, the decline has been nothing less than spectacular; reported cases of polio in the Philippines, for example, fell from 1,422 in 1988 to just 82 in 1990.

Three quarters of all new cases of polio in 1989 and 1990 were reported by China and India. But in both, rising immunization levels hold out realistic hope of eradicating the disease by the year 2000. In Africa, where health systems are generally weaker, the position is less hopeful; 14 African countries still have immunization coverage levels of less than 50%.

Once high levels of routine immunization have been achieved, the key to eradication is a surveillance system that can immediately detect any new case of flaccid paralysis. While laboratory tests determine whether polio is the cause, the suspected case should be 'surrounded' by immunizing all children in the area. Until all countries are free of the disease, no country can be free. Even in nations with very high levels of routine immunization, the polio virus can be imported and may spread rapidly.

Thousands of people and organizations are now involved in the effort to eradicate polio from the face of the earth by the end of the 20th century - the target set by the 1990 *World Summit for Children*. National immunization programmes, whose achievements have been one of the great success stories of the last decade, are being supported by WHO and UNICEF as well as by bilateral aid programmes* and institutions such as the Rockefeller Foundation and Atlanta's US Centers for Disease Control. In an outstanding example of popular support, Rotary International has raised more than $300 million for polio eradication worldwide and provided thousands of volunteers to assist immunization services. In most countries, the task of informing hundreds of millions of parents about the when and the where and the why of immunization could not have been achieved without the support of the mass media, the schools, the religious leaders, and many non-governmental organizations. Two thirds of all costs have been met by the developing world itself.

Eradicating polio from the world will cost approximately $1.4 billion over the next 10 years. But once eradication is confirmed, polio immunization will no longer be necessary. The programme will therefore pay for itself many times over. The savings in vaccines and delivery costs, including savings to the industrialized world, will amount to $500 million a year by the year 2000 and will rise to an estimated $3 billion a year by 2015.

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* USAID has contributed more than $40 million in the last five years to combat polio in the Americas.

A common cause

Part I of this report has advanced the case that an unprecedented gap has been allowed to open up between what *could* now be done and what *is* being done to overcome the worst aspects of poverty. In particular, advances in knowledge which could bring better health, nutrition, and education to millions of families are being denied to the poorest quarter of the world's people. The argument has also been made that, where this gap remains wide, the cause is not primarily a deficiency in resources or in outreach capacity but in commitment and priority. The poor lack both purchasing power and proportionate political influence; therefore the gaps between knowledge and need will not easily be closed either by the invisible hand of market forces or by the visible processes of conventional politics.

In such circumstances, gaps between what is and what could be, between knowledge and need, are not likely to be closed by any automatic or inevitable process of socioeconomic development; they are closed, most often, by large and growing numbers of people who begin bringing pressure to bear for change. Whether acting in defence of their own interests or in solidarity with the rights of others, it is *people's movements* of many different kinds which have in the past succeeded in giving priority to the issues that were being ignored, in making available to the many the benefits of progress that were confined to the few, and in bringing about changes that are today recognized as steps forward for civilization itself.

Several of the panels in this report document the contribution of people's movements to this process of making the benefits of progress more widely available. They show that what today would be called NGOs have been essential to such changes as, the transformation of public health through the provision of safe water and sanitation (panel 7), the control of iodine deficiency disorders in Europe and the United States (panel 10), and the conscious bringing down of infant mortality rates in the United Kingdom and the United States in the early part of this century (panel 8).

More recently, most countries of the world have witnessed two outstanding examples of the power of people's movements to bring change of a fundamental kind and on an international scale: they are the movement for the protection of the environment and the movement for the advancement of women. These causes, too, lacked priority. These causes, too, were unlikely to be advanced, especially in the vital early stages, by either market forces or conventional political processes. And these causes, too, only began their long and unfinished advance when large numbers of people began to know more and care more and do more about the mistakes that were being made and the injustices that were being committed.

It is therefore evident that the struggle to end preventable malnutrition, disease, and illiteracy, the struggle to meet the most basic of human needs and to allow the poorest quarter of humanity to share in the most basic benefits of progress, must also depend, in large measure, on whether or not large numbers of people are prepared to march in this cause. To maintain the political momentum that has so far been generated, and to give the goals that have been agreed a new priority, nothing less is now required than a worldwide strengthening of the basic needs movement to the point where it begins to exert the same kind of pressure as is today being brought to bear for the protection of the environment.

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Europe and the USA: water and sanitation

Achieving the goals agreed at the *World Summit for Children* is largely a task of translating existing knowledge into improvements in the lives of the majority. In the past, this process has usually depended on the efforts of campaigning individuals and organizations that have built popular pressure for governments to take action on a national scale.

In the middle of the 19th century, for example, basic advances were made in knowledge about the links between clean water, safe sanitation, and disease. But only through a determined campaign was this knowledge converted into the levels of public health that are taken for granted in most Western countries today. "*Everywhere*," writes the American social historian Michael Katz, "*public health reform came through struggle.*"

The debate surfaced first in France and Germany, but took on a new urgency in Britain following four explosive outbreaks of cholera that claimed hundreds of thousands of lives in overcrowded industrial towns. British scientist John Snow became the first to link the spread of infection to the contamination of drinking water by the faeces of cholera patients and to suggest that the disease might be caused by invisible organisms (the actual process by which germs spread disease was not discovered until later in the century). So determined was Snow to bring attention to the matter in the face of official indifference that, in a widely publicized incident, he removed the handle of a popular pump on London's Broad Street.

Meanwhile, one of the pivotal figures in public health history was campaigning for legislative action. Edwin Chadwick, a tough, bullying, lawyer who in 1834 had been appointed secretary to Britain's Poor Law Commission, reasoned that filth led to disease, and disease led to loss of income and thus to poverty. In a landmark study of the appalling conditions among Britain's working class, Chadwick claimed that the annual loss of life due to filth and bad sanitation was greater than in any war yet fought. His report, promoting the 'Sanitary Idea', sold 10,000 copies and was read and debated across the country, becoming a rallying cry for a popular movement involving many prominent individuals and organizations.

Chadwick's report remained the driving force behind the public health acts of 1848, 1866, and 1875. Government and water company resistance was gradually overcome, and public health began its forward march through the control of water supply and sewage systems.

In the United States, one of the first public health pioneers was a Massachusetts bookseller, Lemuel Shattuck, who conducted and published a comprehensive health survey of his state in 1850. The survey marked the beginning of a new era in public health in the United States, although no official action was taken on his recommendations until well after his death in 1859. Meanwhile, mushrooming city slums and festering tenements bred epidemic diseases. Almost all families lost children to diphtheria, smallpox, typhoid, and diarrhoea, spurring the formation of voluntary organizations to push for government action. In the 1890s, for example, the Noble Order of the Knights of Labor - dedicated to such measures as action for public health, social insurance, an eight-hour day, and the abolition of child labour - grew from a membership of 11 to more than 700,000. Health reformers, physicians and engineers urged the improvement of sanitary conditions in the industrial cities, supported by many middle- and upper-class women who joined in the campaign for sanitary reform. These voluntary organizations were to provide the framework for many public health reforms throughout the late 19th and early 20th centuries.

Part II of this report is therefore an appeal to individuals and organizations in all countries to become involved in this struggle.

Redefining the acceptable

'People's movements' is a blanket term that must cover many strange bedfellows. Some are movements of the less privileged who are acting in defence of their own interests; others are movements of the more privileged who are seeking to show solidarity with the disadvantaged. Some operate in the broad daylight of civil liberties and freedom of expression; others operate in the dark confines of censorship and repression. Some work at great geographic and economic distance from the causes they support; others have the dirt of daily involvement under the fingernails of their concern. Some advance their cause through the accumulated impact of thousands of small-scale projects, which demonstrate what can be achieved at the same time as showing that public support exists for achievement on a larger scale; others choose the route of acquiring and publicizing the facts, mobilizing public support, carrying their case to the media, lobbying business leaders, and pressing for specific changes in legislation or policy.

By some combination of these methods, people's movements have not infrequently succeeded in bringing about a change that is even more profound and lasting than the sum total of their practical or political achievements. On occasion, they have succeeded, also, in changing the ethical climate of an age, in redefining public and political perception of that which is acceptable and that which is not.

It was such a change in ethical climate that helped to undermine the edifices of slavery and colonialism. It was such a change that, in many nations of the world, brought factory legislation and the ending of child labour. It was such a change that, with a slow and tidal strength, gave millions of working people the right to vote and to be educated. It is such a change that is today pushing back the frontiers of racism and apartheid, rendering unacceptable attitudes and actions which have endured for unquestioned centuries. It is such a change that is beginning to slow the vast and careless momentum of environmental exploitation which, unchecked, would crush the regenerative capacity of the earth itself. It is such a change that is at last beginning to batter at the high and ancient walls which still exclude most of the world's women from the citadels of equality. And it is just such a change that must now be sought in the struggle to overcome the worst aspects of world poverty.

To succeed in that aim, a change will have to be wrought in the ethical climate which shapes and conditions our response to deprivation on today's scale. In the years immediately ahead, the unnecessary deaths of tens of thousands of children each day, and the preventable ill health and persistent malnutrition of so many millions more, must be made into an evil as repugnant and unacceptable as slavery or colonialism was, racism is, and sexism will become.

Every advance in capacity makes a call on civilization to keep step. The narrowing of the gaps between new knowledge and need is therefore a measure of the success of social organization, a test of civilization in the conduct of national and international affairs. It was not an unacceptable disgrace to humanity for large numbers of people to be dying from plagues and fevers when the cause was not understood and the cure was not available. It *is* an unacceptable disgrace to humanity for millions of children to be dying every year from

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Europe and the USA: saving the children

At the beginning of this century, public opinion in industrialized countries became increasingly intolerant of high child death rates, and 'Saving Children' became a rallying cry for many campaigning organizations in Europe and the United States.

Even though environmental sanitation had brought about an impressive drop in disease and death, there had been no comparable fall in mortality rates among very young children. In the England and Wales of 1900, 154 infants died for every 1,000 live births - a death rate far higher than the average for the developing world today.

In the United Kingdom, a popular social movement enlisted health professionals, schoolteachers, local government officials, churches, social workers, and volunteers, under the slogan 'Save the Babies'. Its principal aim was to give mothers the health knowledge that would enable them to improve their own and their children's health. One of its key messages, for example, was the importance of hand-washing, especially after using the toilet or changing a baby's diapers, in order to prevent the spread of diarrhoeal disease which was responsible for about a quarter of all child deaths (as it still is in the developing world today).

Modelled on experiments in France, Britain's first infant welfare centres were largely staffed by volunteers, with a nurse and doctor on hand. By the mid-1920s, the centres had expanded into a countrywide network providing everything from milk and cod-liver oil to nutrition classes and the regular weighing of children. In the city of Oxford, as in many communities, the infant welfare movement was organized not by doctors but by women volunteers. Between 1906 and 1912, the proportion of the city's newborn babies visited by volunteer workers rose from 24% to over 90%.

Health historians credit such 'mother-based' movements with a major role in the fall in the infant mortality rate from over 150 to about 60 in the first quarter of this century. Apart from the direct effects of making available new health knowledge, the movement's emphasis on the frequent weighing of infants also brought mothers and children into regular contact with health workers.

In the United States, people's movements also played a key part in lowering infant mortality rates in the early part of this century. 'Baby health stations', providing milk for nursing mothers and advice on child care, were pioneered by private citizens, and in 1908 Dr. Josephine Baker opened the world's first Bureau of Child Hygiene within the New York City Department of Health. Operating under the slogan 'Better Motherhood, Better Babies, Better Homes', she instituted a system of home visits by public health nurses to advise new mothers on breastfeeding and ways to protect children from diarrhoea and other infections. According to Dr. Baker's own records, the infant death rate in New York declined from 144 per 1,000 births in 1890 to less than 50 per 1,000 in 1939.

After 1900, the National Congress of Mothers set up hundreds of mother's clubs across the nation (changing its name to the Parent-Teacher Association in 1924). In the 1920s, a 'Cleanliness Crusade' took hygiene knowledge across the country via radio and children's cartoons. In 1911, graduate women volunteers were working in 400 inner-city 'settlement homes' to teach home hygiene (strongly supported by the women's suffrage and labour movements). In 1912, women's organizations were also responsible for the setting up of the Federal Children's Bureau, which has since played a leading role in providing maternal and child health services.

diseases that can demonstrably be prevented and treated at almost negligible cost.

The evils of mass malnutrition, preventable illness, and widespread illiteracy are no longer inevitable. They too must therefore be rendered unacceptable. And they too must now be made to retreat from the high ground of domination which they have occupied for so long over the lives of so many.

Solidarity

Many hundreds of organizations, especially in the developing world, are already beginning to respond to this challenge. In particular, many have come forward in support of the commitment made by their political leaders to achieve basic social goals by the end of this century. In some 70 countries, people's organizations of one kind or another have worked with governments in drawing up national programmes of action for achieving those goals. In many more, voluntary organizations have been holding their own national consultations on how best to support a movement towards these targets in the 1990s.

These efforts are just a beginning; and when measured against the demands of the task in hand they are still only a very weak beginning. Not hundreds of organizations but thousands, not thousands of people but millions, will need to give their support to this cause if it is to become a matter of national and international priority.

Unfortunately, a people's movement to meet basic needs, and to protect children from the sharpest edges of poverty, faces an even more difficult task than other movements of similar ambition. The children of the poorest families are the most powerless group in any society; their needs translate neither into voting power nor into purchasing power; and in most cases, parents in the poorest quarter of the world do not have the advantages of education, or wealth, or political influence, or media access.

Such a movement therefore depends, in significant degree, upon all those people and organizations - including the women's movements and the environmental movements - that are willing to act in solidarity with the poorest quarter of the world's people.

The moral basis of that solidarity is obvious. But unfortunately it is difficult to keep the need for that solidarity on today's crowded agenda. The problems of mass malnutrition, illiteracy and disease are 'old' problems, problems that have been with us for so many thousands of years that they have come to be regarded as part of the fixed architecture of existence. They therefore cannot compete in media appeal with the appearance of gaps in the ozone layer, or with explosions in chemical plants or nuclear power stations, or with the dramatic possibilities of global warming. The news of the technological or strategic advances which make it possible to overcome some of these problems also creates very little stir in the media of either the industrialized or the developing world. The dust therefore remains undisturbed on the comfortable belief that only centuries of economic development can deliver the benefits of modern science to the poorest quarter of the world's population.

But perhaps the most difficult problem of all is that these worst aspects of poverty are not newsworthy by the prevailing criteria of the media in almost all nations. Unlike even the sudden disasters of drought or famine or flood, the death of 35,000 children each day from malnutrition and disease is not an event that happens in one place at one time or from one televisual cause. It happens every day, and it happens quietly in poor communities throughout the developing world. It is therefore not 'news', and so it slips from the public eye and from the political agenda.

This does not make the tragedy of those families any the less real. The importance of an issue should not be entirely decided by its novelty or its photogeneity. There is something amiss when the world can react with horror and compassion in the face of sudden disasters, of famines and floods, while remaining unaware or unmoved by the vastly greater toll of death and malnutrition taken by ordinary, preventable diseases like measles, diarrhoea, and pneumonia. And there is also something amiss when a passionate cry goes up over the loss of biodiversity while cold silence greets the unnecessary deaths of so many thousands of children each day. It is unacceptable for the tragedy of these children's lives and deaths to continue when the means exist to prevent it. And not to act in solidarity with their needs, at this time, is to tacitly acquiesce in the verdict of a world which says that these children do not matter because they are the children of the poor.

The practical basis for solidarity is equally strong. If the basic social goals that have been agreed can be reached, if children can be protected from the worst aspects of poverty, then a profound contribution can be made to several of the great causes that are now of prime concern to the world as a whole. Sustainable economic growth, progress towards equality for women, the protection of the environment, the slowing of population growth, the achievement of greater equity and political stability - all of these would be advanced by doing what can now be done to meet basic human needs and to protect children from the worst aspects of absolute poverty.

The cause of children and of the poorest families, the cause of those least able to demand priority for their own rights and needs, therefore warrants support on both moral and practical grounds. And it warrants the support of all those individuals and organizations, in all countries, that are involved in any and every aspect of the struggle for a more just and more sustainable world.

Population

To take the issue of rapid population growth first, Maurice Strong, Secretary-General of the 1992 *United Nations Conference on Environment and Development*, pointed out during the build-up to the Earth Summit that "*the effort to reduce illness and malnutrition, and to reach the goals of the World Summit for Children, is crucial not only for its own sake but also as a means of helping to slow population growth and make possible environmentally sustainable development in the 21st century and beyond.*" Backing this statement are the hundreds of demographic studies which show that the four principal factors[31] involved in the slowing of population growth are: the education of girls and women; the availability of health services and the lowering of child death rates; the availability of family planning services; and increasing incomes. But probably the most powerful factor of all is the synergism between these forces; acting together, they can exert a far greater downward pressure on birth rates than the sum of their individual effects. And even in the absence of one of the factors - significant improvements in incomes - countries such as China, Sri Lanka, and the Indian state of Kerala have shown that the reduction of child deaths, the education of girls, and the availability of family planning services can together bring birth rates down almost to the levels of the industrialized world.

These three social factors in the population equation are among the most prominent of the basic social goals that have been agreed. Those goals include a one-third reduction in child deaths, family planning information and services for all, and a basic education for all children. As achieving these goals would reduce child deaths, so it would give parents the *confidence* to have smaller families. As it would make family planning services available, so it would give parents the *means* to have smaller families. And as it would bring education to 100 million children who are now not in school - most of them girls - so it would make the parents of the future more likely to *choose* smaller families.

If ever there was an obvious case for priority action, it is therefore surely the achievement of these particular goals. All of them are important human advances *in their own right*. All of them interact to improve the lives and the health of millions of women and children. All of them can be accomplished at relatively low cost. All of them give people more choice and more control over their own lives. And all of them make a strong and synergistic contribution to lowering the rate of population growth and can therefore reduce the gradient of the road to sustainable development.

Environment

A movement to meet the basic needs of all children therefore makes common cause with the need to reduce rates of population growth. But it also joins hands with the environmental movement on other fronts.

From the point of view of millions of the poorest families on earth, a principal environmental concern is the ever-present threat of disease in their immediate surroundings. The greatest threat to their lives and health is not pollution of water by chemicals but pollution by foecal organisms, not industrial waste but human waste, and the greatest of their environmental problems is the lack of the clean water and safe sanitation which alone can protect them against diarrhoeal disease, schistosomiasis, hookworm, guinea worm, cholera, and typhoid. This is the silent environmental crisis; and it takes its daily toll on the life and health of millions of those whose voice deserves to be heard in the environmental debate.

Second, reaching the goal of a basic, relevant education for all children also interlocks with the movement for environmental protection. Education and re-education about environmental issues is the key to saving the planet. Making people aware of the facts, of the fragility and unity of ecosystems, of the often hidden environmental dangers to health, of the real impact of human activities, of the long-term consequences, of the choices and alternatives, is and will continue to be the main hope of the environmental movement. But without basic education and literacy, millions of people will be denied such knowledge and choice; they will be less able to absorb new information, make informed decisions, and adapt to the many changes that the 21st century will surely bring.

Finally, the meeting of basic human needs also joins in common cause with environmental protection because a large proportion of the world's people cannot reasonably be asked to turn their attention and their efforts to the question of long-term sustainability while they are preoccupied with the desperate struggle for short-term survival and the meeting of their minimum human needs.

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The Earth Summit: children and *Agenda 21*

The Earth Summit (officially the United Nations Conference on Environment and Development) met in Rio de Janeiro, Brazil, in June 1992. The outcome of the *Summit* was a *Declaration* and an *Action Plan* endorsed by 118 of the world's heads of State and Government.

Despite some disappointment that a more legally binding charter could not be agreed, the *Rio Declaration* (a non-binding statement of principles) clearly sets out the case for a more sustainable pattern of development. It also emphasizes the eradication of poverty, the equal rights of women, and "*the creativity, ideals and courage of the youth of the world*" as vital factors in achieving a better future for all.

But the real achievement of Rio was *Agenda 21* - the action plan for environment and development to take the world into the 21st century.

This massive, 500-plus page document, approved by the world leaders, resulted from more than two years' negotiation by the world's governments and thousands of other organizations and individuals.

Agenda 21 reinforces the commitments made at the *World Summit for Children* with these words:

"*Specific goals for child survival, development and protection were agreed upon at the World Summit for Children and remain valid also for Agenda 21. Supporting and sectorial goals cover women's health and education, nutrition, child health, water and sanitation, basic education and children in difficult circumstances.*"

"*National Governments, according to their policies, should take measures to:*

(a) *ensure the survival and protection and development of children, in accordance with the goals endorsed by the World Summit for Children;*

(b) *ensure that the interests of children are taken fully into account in the participatory process for sustainable development and environmental improvement.*"

Chapter 25 of *Agenda 21* is devoted to children and youth and specifically urges governments to:

○ implement programmes to reach the goals set by the *World Summit for Children*;

○ ratify and implement the *Convention on the Rights of the Child*;

○ promote primary environmental care activities to improve the environment by meeting basic needs and empowering local communities;

○ expand children's education, especially for the girl child;

○ incorporate children's concerns into all relevant policies and strategies for environment and development.

Other chapters - on health, women, water, education, poverty, and population - also endorse the goals set by the *World Summit for Children*. The population chapter, for example, recommends that all women be informed about the advantages of breastfeeding and stresses the importance of reducing maternal and child mortality through the improvement of health care.

As with the *World Summit for Children*, the long struggle must now begin to keep the promises made at Rio and to meet the needs of present generations without pre-empting the possibility of a decent life for generations yet unborn.

The United Nations Conference on Environment and Development was the most significant attempt yet made to unite these concerns of poverty and environmental degradation (panel 9). The agreements it came to are reflected in two major documents - the *Rio Declaration on Environment and Development* and *Agenda 21*. The *Declaration* states that the eradication of poverty is indispensable to sustainable development. And *Agenda 21* also states, "*Specific major goals for child survival, development and protection were agreed upon at the World Summit for Children and remain valid also for Agenda 21.*"

The women's movement

Meeting basic needs - especially for primary health care, family planning and basic education - would also make a fundamental contribution to the worldwide women's movement.

A central concern of hundreds of millions of women, women who are for the most part silent partners in that movement, is the survival, health, and normal physical and mental development of their children. This concern absorbs the majority of their time, worry, efforts, and resources. And there could be few greater contributions to their lives than the easing of that task. Immunization, control of diarrhoeal disease and acute respiratory infections, vitamin A and iodine supplementation, safe water and sanitation - all of these could provide practical support to millions of women who are at present denied this assistance because it is not a sufficient priority.

If there is a larger contribution that could be made to the lives of women in the world's poorest communities, then it is the achievement of another of the basic needs goals - the universal availability of the information and services to enable people to plan the number, timing, and spacing of births.

Control over the timing of births is today almost taken for granted by most women in the industrialized world. But it is a revolution yet to come to many millions of women for whom the benefits would be even greater.

Family planning would save the lives of between a third and a quarter of the 10,000 women who die *every week* from the complications of giving birth. It could also protect unknown millions of women from permanent and painful disabilities that can occur in childbirth and are more common when pregnancy is unwanted. And it would certainly reduce the toll of the illegal abortions, estimated at approximately 50,000 *each day*, that result in an estimated 150,000 young women dying each year.

At stake here is not only the quantity of women's deaths but the quality of women's lives. By freeing women from the constant bearing and caring for children, family planning can increase the time, energy, and resources available for education, for learning new skills, for income earning, for participation in a wider range of community activities, and for the rest and leisure almost totally denied to many millions of women in the poorest strata of society.

Finally, achieving the goal of basic education and literacy for all children would strengthen the roots of the worldwide movement towards equality for women. Girls are almost universally discriminated against when it comes to education. And even from a purely practical point of view, this is one of the most costly mistakes that any society can make. Hundreds of studies in recent years have shown that the education of girls is strongly

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Iodine: a Spanish lesson

For over 70 years it has been known that the addition of minute quantities of iodine to salt can solve the health problems caused by lack of iodine in the diet. Less than a teaspoonful of iodine is required for a whole lifetime; but without it a range of iodine deficiency disorders (IDD) soon make themselves felt. The most visible consequence is the appearance of goitres around the neck. But the invisible results are more insidious; hundreds of millions are today living out their lives with reduced mental and physical capacity caused by an iodine deficiency problem that, for the most part, they are not even aware of.

About 1 billion people are at risk. Most vulnerable are the very young. Iodine is essential to the hormone that regulates normal growth and development and iodine-deficient children can be stunted, listless, mentally retarded, or incapable of normal speech, movement, and hearing.

The solution is simple and inexpensive. Because all humans eat salt, and because iodine can be added to salt without affecting its appearance or taste, IDD can be eliminated by iodizing all salt at the point of processing or packaging. The cost is so small - approximately 5 cents per person per year - that it can usually be absorbed in the market cost of the salt. Given the cooperation of the salt industry, large and recurring public expenditures should not be necessary to solve this problem.

Switzerland and the United States were the first countries to iodize commercial salt supplies. In 1922, a Swiss doctor, Hans Eggenberger, organized a petition in his home canton to persuade the authorities to iodize all salt as it came through the railway station from the salt-works. The benefits quickly became evident, and soon most cantons had passed similar legislation. "*Iodized salt has, without any doubt, been the most cost-effective preventive health measure ever adopted in Switzerland*", says a recent study of the Swiss experience.

Meanwhile in Spain, the Government of the time was taking the view that there was no need to target iodine deficiency specifically and that the answer to the problem was overall economic development. As a result, IDD remained a serious but unacknowledged problem in parts of Spain until the mid-1980s. Even then, only an extraordinary private initiative by a Spanish doctor, who persuaded colleagues to spend their vacations collecting data on IDD, finally persuaded the state to open up the problem for public debate and to fund a national survey.

In the developing world, the main problem to date has been the lack of public and political awareness of the severity of the problem and the simplicity of its solution. But following the 1990 *World Summit for Children*, where the target of eliminating IDD in this decade was accepted by political leaders, a number of countries have begun to move towards the iodization of all salt supplies. Ecuador and Tanzania are bringing the problem under control. During 1993, Bhutan and Bolivia will achieve the goal of zero new cases. By 1995, both China and India could be producing enough iodized salt for their entire populations.

In many countries, it will take several more years to put in place the legislation, the technology, and the necessary control procedures to ensure that all salt is properly iodized when it reaches the consumer. But in the meantime, populations known to be at risk can be given iodine by injection or by capsule at a cost of little more than 10 cents per person per year.

associated with the confidence to adopt new ways; the willingness to demand and to use health services; the capacity to adapt to new opportunities and to earn higher incomes; the protection of local environments; the more efficient use of family resources; the lowering of child death rates; the improvements of family health and nutrition; the use of family planning services; and the reduction of average family size.[32]

Empowering women with at least basic education and literacy is therefore one of the most important single elements in the development process. But it is also one of the most important steps towards women gaining more control over their own lives, more influence over the community and family decisions that affect those lives, and more opportunity to develop their own potential.

Political advance

Finally, the growing movement for democracy and for greater equity can also support, and be supported by, the movement to overcome the worst aspects of poverty and to meet the basic social goals that have been agreed.

In particular, education and literacy are the soil in which democracy and participation flourish and in which greater equality of economic opportunity becomes a realistic possibility.

Action on many levels, and redress for many wrongs, is needed to correct the unacceptable degrees of inequality both within and between nations. But direct action to protect the poorest, and especially children, is fundamental to the process of narrowing those great inequalities of resources, capacities and opportunities.

The cause of overcoming the worst aspects of poverty and reaching basic social goals therefore strengthens, and is strengthened by, all of the major causes of our times. And it is time that these powerful links found practical expression. Those at the sharpest end of the problem of absolute poverty - the poorest quarter of the world's people - are occupied almost every waking hour of every working day in the struggle to meet the basic needs of their families. They are struggling in a day-to-day practical sense; and, in many cases, they are struggling in an organized political sense. And what they need is the practical and political support of thousands of individuals and organizations, in all countries, who are prepared to show solidarity with that struggle and know enough about its causes and consequences to recognize the power of *common cause.*

11

Emergencies: a new ethic

Progress towards the achievement of specific development goals, such as those discussed in this report, is often disrupted by disasters and emergencies, armed conflicts and economic crises. While many cross-border wars seem to be winding down with the ending of the cold war, there appears to be an almost corresponding increase in ethnic violence and civil strife.

With today's communications capacity, such disasters no longer go unnoticed by the international community. Public opinion demands that relief actions be taken to alleviate human suffering. The widespread criticism of slow or inadequate response to the crises in Somalia and in the former Yugoslavia is an indication of this new global ethic.

But coping with disaster need not always be a diversion from development. In some cases, emergency actions can have a positive long-term impact through improving organizational capacity and through accelerating vital, low-cost programmes such as immunization, oral rehydration therapy, and low-cost water and sanitation schemes. Well-designed emergency programmes include plans for rehabilitation and a return to the rails of longer-term development.

Emergencies may be unpredictable, but emergency preparedness can be planned. In the mid-1980s, Botswana suffered six years of the worst drought of this century but still managed to hold the line against famine and malnutrition at a cost of barely 2.5% of GNP. And at the end of the 1980s, several states in India withstood two years of severe drought that, in any previous era, would have brought mass famine to millions of people. So effective was the Indian Government's action in moving in food aid and mounting food-for-work that disaster was avoided.

These examples show that famine prevention through household food security is cost-effective, helping to avoid disasters at the same time as contributing to long-term development.

The overriding obligation to provide humanitarian relief even in the midst of war and civil strife is an idea that has gained increasing acceptance in recent years. The right and duty of the international community to intervene to protect innocent civilians, especially women and children, is now being recognized worldwide. The *Convention on the Rights of the Child* and the *Declaration of the World Summit for Children* have reinforced this new ethic with the force of international law and high-level political commitment.

A similarly welcome development in the post-cold war era has been the willingness of the international community to work through the United Nations to impose economic sanctions against governments that violate the UN Charter. But sanctions are a double-edged sword. Often the heaviest consequences fall on those who are least culpable and most vulnerable. 'Humanitarian supplies' may be specifically excluded from economic sanctions but this does not mean that essential supplies will reach those in greatest need. In many cases, the poor and the vulnerable have suffered 'double sanctions' as their pre-existing deprivation is suddenly made worse by scarcities and rising prices. Meanwhile, sanctions have often brought only minor inconvenience to the wealthy and the powerful.

Experience shows that there is no easy way to impose 'sanctions with a human face' so that they will punish the culpable and protect the vulnerable. But it is imperative to think through in advance the possible impact on the unintended victims, and to plan countervailing measures to mitigate their suffering.

A movement for basic needs

Movements to meet basic needs already exist, in some form, in almost every country. There are thousands of organizations in both industrialized and developing worlds campaigning to promote education, or to protect children against disease, or to end hunger in the world, or to promote family planning, or to encourage breastfeeding, or to combat specific problems such as iodine deficiency or vitamin A disorders, or to support immunization and polio eradication, or to promote today's health knowledge, or to help street children, or to protect children who are abused at home, at work, or in war.

The great majority of such groups are now located in the developing world, and their growth has been one of the most remarkable features of recent years. "*From the middle of the 1970s,*" says a 1992 report from the OECD, "*a trend of growing importance has been the emergence of indigenous non-governmental organizations in the South as active partners in development efforts. In the 1980s, conservative estimates put their number at 6,000 to 8,000.*"[33]

Other sources put the number of independent development organizations at 12,000 in India alone, including many, such as the *People's Science Movement*, that are working specifically to put today's knowledge and technology at the disposal of the poorest communities. In Pakistan, at least 3,000 NGOs are also working directly with communities to meet obvious human needs.[34] In Indonesia, there are at least 600 independent organizations concerned with development issues. In Mexico, there are known to be more than 250. In the Philippines, there are 200 organizations helping to meet the needs of street children.

In the industrialized world, also, many hundreds of organizations are involved in this struggle against the worst aspects of poverty. Some focus their efforts on the raising of funds for practical projects in the developing world. Some are engaged in the long-term processes of public education or in campaigning for political and economic change. Many are involved in both of these activities.

Today, NGOs in both industrialized and developing nations are beginning to mobilize in support of the specific basic needs goals agreed on at the *World Summit for Children.*[35] Such involvement is specifically invited in the *Plan of Action* drawn up at the *Summit*: "*Families, communities, local governments, NGOs, social, cultural, religious, business, and other institutions, including the mass media, are encouraged to play an active role in support of the goals enunciated in this Plan of Action. The experience of the 1980s shows that it is only through the mobilization of all sectors of society, including those that traditionally did not consider child survival, protection and development as their major focus, that significant progress can be achieved in these areas.*"[36]

As a result, NGOs in about half of the developing countries have participated in the drawing up of national programmes of action for reaching the basic humanitarian goals agreed at the *World Summit for Children* and endorsed by the *United Nations Conference on Environment and Development*. In some countries - Costa Rica, the Dominican Republic, Ghana, Jamaica, Malaysia, Niger, the Philippines, Zimbabwe - NGOs have been officially invited to join the government commissions charged with drafting national programmes of action. In others - Argentina, Bahrain, Benin, Bolivia, Botswana, India, Kenya, Mauritius, Nepal, Pakistan, the Sudan, Tanzania, Thailand, Yemen - NGOs have participated by holding their own national consultations.

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Brazil: a children's movement

The killing of street children in Brazil has rightly brought worldwide condemnation. Less well known are the efforts of thousands of individuals and organizations in Brazil to build a children's rights movement.

Under two decades of dictatorship, the law itself had become an instrument for the oppression of children in Brazil. Thousands were sent off to harsh correctional institutions simply because they were poor and abandoned. Such children had no legal rights, and abuse by police and other authorities had become the norm.

When democracy returned in 1985, the same laws and institutions remained in place, and many of the same attitudes and practices prevailed in the judiciary, the police, and in the large and overcrowded institutions. But now it was at least possible to begin campaigning for change. And in the same year that elections were held, 200 of the non-governmental organizations (NGOs) working on behalf of Brazil's street children formed themselves into a national street children's movement. From its experience of working with such groups, UNICEF was able to help bring interested parties together and to provide a wide range of advice. The new Government, which openly acknowledged the problems, set up a children's agency that actively encouraged NGO participation.

The most fundamental task of the new movement was to restore the very idea of children's rights to Brazilian society and its institutions. The drafting of the country's new Constitution offered a perfect opportunity. With the support of many in the Catholic Church, the media, and the legal and medical professions, the children's rights movement began a national campaign which, in the last six months of 1986, saw almost 3,000 articles and 72 television programmes on children's rights. In May 1987, the President of the Constituent Assembly was handed a petition signed by 1.3 million Brazilians supporting the idea that children's rights should be built in to the new Constitution. The children's rights movement had arrived.

Constitutional change was achieved. But this had to be followed by changes in law and policy. Supported again by the Church, the media, and by reform-minded judges and government officials, a campaign began to replace repressive legislation by a new Children's and Adolescents' Statute. Under the proposed law, the power of the courts to deprive children of freedom was to be limited to cases in which the law had been broken. If possible, abandoned children were to be returned to their families. If not, then they were to be put into the care of institutions that would be as small and family-like as possible. Children in care would be allowed to attend ordinary schools and remain a part of the community.

Once again, thousands of individuals and organizations mobilized in support of the new law, and in 1990 it was approved by Congress and ratified, without changes, by the President.

There is still a long way to go before anyone can be content with what has been done to protect children's rights in Brazil. But the constitutional and legal changes that have been brought about are the essential foundations for progress. Institutions for children are beginning to provide training and to help with income-earning opportunities. Many states have set up SOS telephone lines, and NGOs have also set up children's and adolescents' defence centres, often staffed by volunteers. Almost every state and municipality now has a council for the rights of the child on which NGOs and government have equal representation. Today, abuse of children no longer goes unprotested.

In some countries, also, NGOs have decided to devote their efforts to the achievement of particular goals - either with or without government cooperation. In Bangladesh, for example, six organizations - *Swanirvar Bangladesh, Village Education Resource Centre, Dhaka Ahsania Mission, Jagoroni Chakra, the Bangladesh Literary Society, and the Bangladesh Rural Advancement Committee* - are working with the Ministry of Education to move towards the goal of a basic education for every boy and girl by the year 2000. In Indonesia, the *Indonesian Midwives Association* is a driving force behind the 'safe motherhood initiative' which has brought together many NGOs in an attempt to achieve the *Summit* goal of halving maternal mortality rates by the end of the century. In Egypt, the Egyptian branch of the *International Law Association* and the *Society of Medicine and Law* mobilized public support for Egypt to become one of the first countries to ratify the *Convention on the Rights of the Child.* In Brazil, NGOs working with the country's street children created the *National Street Children's Movement* which successfully lobbied for children's rights to be explicitly recognized in the country's new constitution (panel 12).

In the industrialized world, a smaller number of NGOs are beginning to move in support of these specific goals. The Washington-based *Results* group has generated scores of editorials in major newspapers in its campaign to support the goals agreed at the *World Summit for Children* and to triple the proportion of United States aid allocated to primary health care and basic education. In several countries, organizations such as *World Vision International* and the *International Save the Children Alliance* have sponsored mass letter-writing campaigns to political leaders, media representatives, and corporate executives, to remind them of the basic social goals which were agreed on at the *Summit*.

Other NGOs are focusing on particular goals. The *International Planned Parenthood Federation*, to take one of the most important of all examples, has made and is still making a major contribution to the goal of making family planning universally available and to the reduction of maternal mortality. The *International Federation of Red Cross and Red Crescent Societies* has launched its *Child Alive* programme to help put into practice today's low-cost methods of controlling the major childhood diseases. Groups such as the *International Baby Food Action Network*, the *World Alliance for Breastfeeding Action*, and *La Leche League International*, are making an impact on malnutrition through their campaigns to stop the promotion of commercial infant formulas in the developing world and by working to empower all parents with today's knowledge about the advantages of breastfeeding (panel 13). *Junior Chamber International*, whose members include young men and women in over 100 countries, has contributed professional skills to help control the devastating impact of diarrhoeal disease. *The Christian Children's Fund* has launched a programme to achieve the agreed goals for the half million children reached by the organization. *Rotary International*, also active in over 100 countries, has raised more than $300 million in support of polio eradication and mobilized an army of volunteers to help with the logistics of the eradication campaign.

This last example should again give pause for thought to those who might assume that such efforts can only ever be small-scale gestures which are of no real significance in the larger picture. In India alone, *Rotary International* has fielded 50,000 volunteers to help with vaccination efforts and has doubled that number on national immunization days. And on WHO's recently published list of major donors to the Expanded Programme on Immunization, the sixth name was not the government of an industrialized nation but *Rotary International* - whose $300 million contribution exceeds that of the governments of Canada, Sweden, the United Kingdom, or the United States.[37]

In other words, there are already thousands of organizations which are working in large ways and small, politically and practically, nationally and locally, towards the achievement of basic social goals.

But this cannot yet be described as a movement that has sufficient weight of public and media support, or the sense of time-related common aims, to begin bringing to bear the sustained political pressure which is needed. Only when the climate of opinion begins to turn, when mass malnutrition, disease, and illiteracy are widely perceived as unacceptable and shameful, will today's solutions be put into practice on the same scale as today's problems. And to achieve that change, literally millions of people and thousands of organizations will have to be prepared to stand up and be counted in support of this cause.

Media support

In both developing and industrialized nations, there are particular occupational groups which could make a potentially decisive difference.

In particular, the media in most countries is becoming the chief midwife of peaceful change. It is communication, not violence, that has delivered so many nations from dictatorship in recent years. It is communication that is nourishing democracy and popular participation by creating new levels of public awareness. It is communication that has built the environmental and women's movements over the last decade. It is communication that has made possible the dramatic rise in immunization levels in the developing world. And it is communication that could now make a similarly massive contribution to the cause of meeting basic needs.

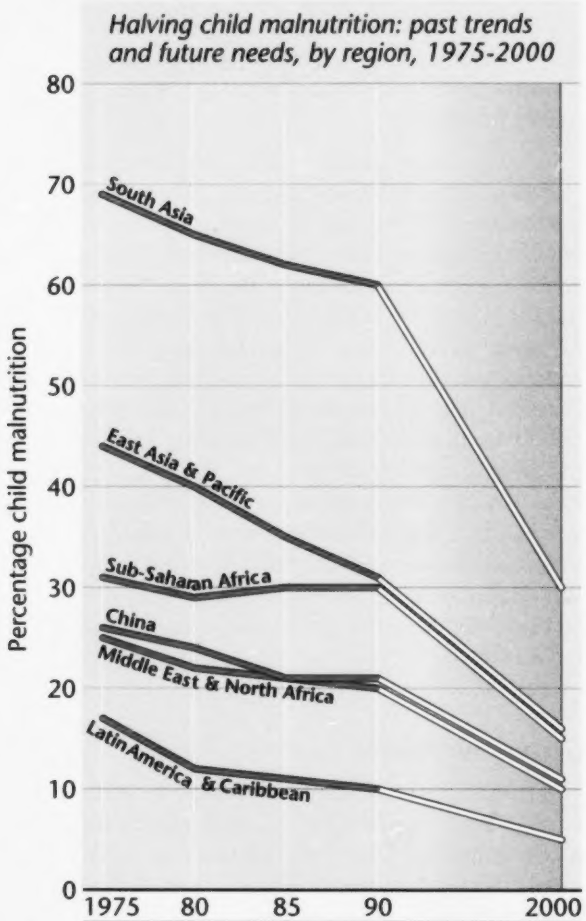
In so far as it is possible to generalize at all, media coverage of basic poverty issues tends to consider only what is and not what could be, to focus only on the actions taken and not on the opportunities missed or on the larger picture of need. And if the media is to make a serious commitment to both stimulating and reflecting growing public support for meeting basic needs, then a new kind of journalism-against-poverty will have to be pioneered. Local priorities and local circumstances will dictate the nature and content of that journalism; but its aim must be to keep public and political leaders interested and informed of the main facts and trends, the gains made and the needs still unmet, the new technologies and the attempts to apply them on a sufficiently large scale, the human consequences and the economic implications.

Media professionals themselves are best able to decide how this contribution can be made. But in the gaps between today's capacity and today's reality, there is scope for a decade of reports and investigations, analyses and editorials. Subjects which the news media could legitimately be expected to investigate, in those countries which now enjoy press freedoms, might, for example, include:

- What proportion of the nation's children are growing normally in mind and body and

Fig.10 Progress against malnutrition

The *World Summit for Children* set the goal of halving the 1990 level of child malnutrition by the year 2000. This chart presents the first estimates of regional trends in malnutrition. The white lines show that achieving the target will require an acceleration of present progress, particularly in South Asia and sub-Saharan Africa.



Malnutrition is defined as more than two standard deviations below the desirable weight for age. Child malnutrition refers to the child population under five years of age.

Source: *Second Report on the World Nutrition Situation*, ACC-SCN, 1992.

what proportion are being stunted by malnutrition? (fig. 10) Is the nutritional health of the nation's children being regularly monitored? Is it easier to find out how many households have television sets than it is to find out how many children suffer from malnutrition?

- How many thousands of children have died from measles or tetanus in the last year and what proportion are immunized against these diseases? (figs. 8 and 6, and panel 4) Are there areas of the country, or classes in society, that are being bypassed by immunization services?

- How many of a nation's children have been crippled by polio in the last 12 months and what progress is being made towards 'surrounding' and eradicating the virus? (fig. 7 and panel 6)

- Is it known how many children are losing their health and/or their eyesight each year because of vitamin A deficiency and what, if anything, is being done about changing diets or adding vitamin A to national supplies of salt or sugar? (panel 13)

- How many children are being born mentally damaged because of iodine deficiencies and are plans being made, and funded, for the iodization of all salt supplies or the use of iodine injections?

- What is the average age of marriage and of first pregnancy? How many babies are being born in the 'critical zone' (less than two years since a previous birth, more than four births in total, mother aged under 18 or over 35)[38], and what proportion of couples have access to family planning information and services?

- How many women are dying and being disabled in childbirth? What are the causes? What is being done to extend emergency obstetric care to rural areas? (panel 14)

- How many children are still dying from diarrhoeal disease and how many parents have been informed about life-saving oral rehydration therapy? (panel 5)

- Are acute respiratory infections the biggest killer of the nation's children, and what is being done to make antibiotics available in time?

- What is the country's under-five death rate and is it significantly higher or lower than in countries at similar levels of economic development?

- What proportion of children are born weighing below 2,500 grams (low birth weight)? How does this compare with neighbouring countries? And what does this say about the health and well-being of the nation's women?

- What percentage of the nation's children are attending primary school? (fig. 11) How many drop out before becoming literate and why? Are more boys enrolled than girls? What are the reasons behind high drop-out rates?

- What proportion of babies are exclusively breastfed for the first six months of life? How many infant deaths are estimated to be caused each year by the drift towards bottle-feeding? Has government banned the advertising of commercial infant formulas? Are free samples of infant formula still being given away in maternity units? (panel 13)

- Has the *Convention on the Rights of the Child* been ratified? Are its provisions being violated? What changes in national law and policy are being made to enforce it?

- What proportion of government expenditures are allocated to meeting the most obvious and basic of human needs? Is priority given to low-cost services for the many or more expensive services for the few?

- Are there significant differences between rates of illness and death, malnutrition and illiteracy, between girl and boy children, or between rural and urban areas, or between different districts or provinces?

In both industrialized and developing countries, critical attention could also be paid to how foreign aid is being used; what proportion finds its way to the poorest groups, to primary health care, to basic education, to low-cost water and sanitation programmes, to family planning?

The questions and the style of the coverage will vary, but media proprietors, editors, and journalists will find no shortage of subjects which, on grounds of both national importance and human interest, could sustain a decade of intense media attention in support of basic needs goals. Sporadic and casual reports will not lift this cause; nothing less is required than a decade of intense and sustained media attention and scrutiny of the progress being made towards meeting the basic needs of the poorest quarter of a nation's people. But if a sufficiently large number of respected media professionals were to take up this challenge in the years ahead, then the public and political pressure to meet agreed basic needs goals would be very substantially increased.

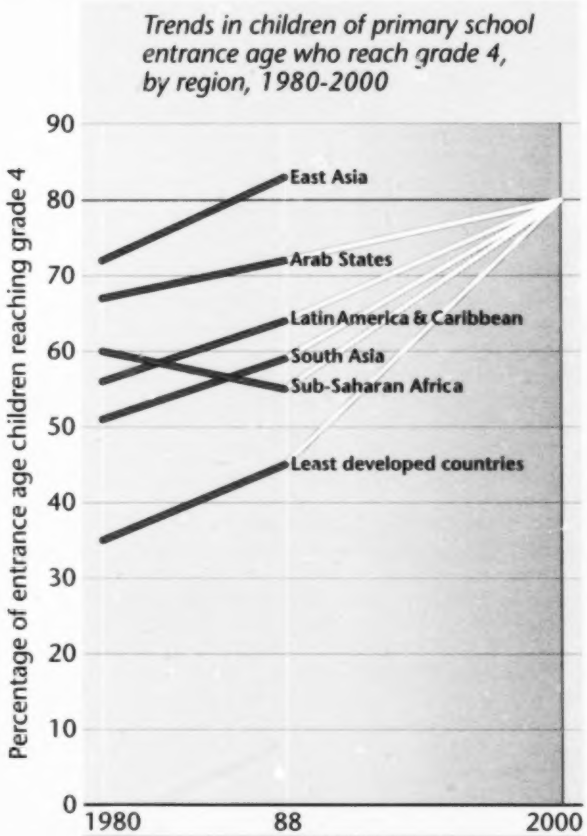
Health professionals

Health professionals in the developing world already make one of the most significant of all contributions to the meeting of basic needs. But it is a contribution that could be multiplied many times over in the 1990s.

The number of health professionals has more than doubled in the past decade, and there are now well over 2 million doctors and over 6 million nurses, auxiliary nurses and

Fig. 11 Primary education

One of the year 2000 goals set by the *World Summit for Children* was that all children should receive a basic education and at least 80% should complete primary school. The chart shows what proportion of children in each region now reach grade 4 of primary school. The white lines indicate the progress needed to achieve the target.



Countries do not always report the age of primary school children entering first grade. Where age is not reported and the number of new entrants was lower than the corresponding population, it was assumed that all new entrants were of the official entrance age. Since many of these new entrants are older, the data in the chart indicates a higher level of achievement than actual.

Source: *The Impact of Primary Education on Literacy* (STE-8), UNESCO.

midwives in the developing world. Along with health administrators, heads of medical colleges, paediatricians, hospital administrators, and medical researchers, these professionals form a vast army of potential support for bridging the gap between today's knowledge and technology and its widespread use.

It is true that some health professionals have made themselves more a part of the problem than the solution. In some nations, doctors have encouraged bottle-feeding, continued to prescribe antidiarrhoeal drugs instead of oral rehydration salts, and opposed the use of antibiotics by community health workers. But increasing numbers of today's health professionals are beginning to use their influence in other directions:

- They are advocating strategies of primary health care and opposing the allocation of the great majority of health resources to city hospitals.

- They are exploring ways to make more efficient use of highly qualified medical personnel by deploying them in support of the training, supervision, and referral back-up to community health workers.

- They are using their influence to make the health benefits of family planning more widely known.

- They are supporting the use of oral rehydration therapy and arguing the case, within the profession, that community health workers should be allowed to prescribe antibiotics (panel 1).

- They are promoting breastfeeding, supporting the campaign to make all hospitals and maternity units 'baby-friendly' (panel 13), and helping to monitor the international code on the marketing of infant formulas.

- They are helping to monitor micronutrient

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Breastfeeding: baby-friendly hospitals

Fifty-two hospitals in 12 countries were declared 'baby-friendly' early in 1992, and hundreds more are expected to have earned the title by the end of the year. The aim is to bring about a revolution in the way hospitals treat newborn babies and their mothers.

For many years, most hospitals have discouraged breastfeeding. Newborn babies have usually been kept apart from their mothers and bottle-feeding has been the norm. Manufacturers of infant formulas, fighting for market share, have routinely provided hospitals with free or subsidized milk-powder. Millions of mothers, anxious to do what is best for their children, have been persuaded to bottle-feed. The result has been a steep decline in breastfeeding - reinforced by advertising and by the worldwide rise in the number of women who go out to work.

For the last decade, WHO and UNICEF have been campaigning to reverse this trend. Breastmilk is more nutritious, more hygienic, immunizes babies against common illnesses, and reduces the mother's risk of breast and ovarian cancer. Infant formula, apart from being expensive, is often over-diluted with unclean water and fed to children from unsterile feeding bottles. In poor communities, the difference is so vital that an estimated 1 million young lives could be saved every year if the world's mothers went back to exclusive breastfeeding for the first four to six months.

What happens in hospitals is probably the most important point of leverage in this struggle. Many maternity units have long been on the side of the bottle, failing to give mothers proper information on the benefits of breastmilk and implicitly favouring, and giving status to, infant formula products. It is for this reason that WHO and UNICEF launched the baby-friendly hospital initiative in mid-1991. The idea is to persuade all hospitals to follow the 'Ten Steps to Successful Breastfeeding' - which includes informing all mothers of the advantages of breast-milk, keeping newborn babies in the same room as their mothers, rejecting the use of feeding bottles, and helping mothers with any problems they may have in beginning breastfeeding. Hospitals which follow the 10 steps are designated 'baby-friendly'.

Initially, the campaign aimed at 'baby-friendly' status for leading hospitals in 12 countries - Bolivia, Brazil, Côte d'Ivoire, Egypt, Gabon, Kenya, Mexico, Nigeria, Pakistan, the Philippines, Thailand and Turkey. One year on, that aim had been achieved. The next stage is to extend the award to at least 100 hospitals in each of eight regions - including the industrialized world. By 1995, the hope is that hospital practice will have been transformed in all countries.

Meanwhile, the International Association of Infant Formula Manufacturers has also agreed that, in countries where the government supports the baby-friendly initiative, its members will stop all marketing to hospitals and maternity units by the end of 1992.

If all of this can be achieved, the campaign will help the world to achieve not one but several of the most important goals agreed on at the 1990 *World Summit for Children* - including a one-third reduction in child deaths and a halving of child malnutrition. And, like many other actions needed to reach the goals, going 'baby-friendly' is largely a matter of substituting good practice for bad and therefore requires very little in the way of extra resources. For the hospitals themselves, costs will actually be reduced as infant formula, feeding bottles, and separate nurseries become unnecessary. One of the first to go 'baby-friendly', the Jose Fabella Memorial Hospital in the Philippines, has already reported saving 8% of its annual budget.

deficiencies and raising awareness of these hidden problems and their low-cost solutions.

- They are attempting to demystify medical knowledge and to put essential information at the disposal of all families.

Through their professional organizations, health workers at all levels are also beginning to contribute to bridging today's gap between knowledge and need. The *International Council of Nurses*, representing 1 million nurses in all countries, is training its members to inform parents of today's low-cost methods of protecting the vulnerable years of growth. The *International Pediatric Association* has also called on its three quarters of a million members to use "*the combination of technology, communication, and social organization which could reduce the toll of diseases and death of children by half.*" The *Fédération internationale pharmaceutique* has recommended its 700,000 pharmacists in 65 countries to promote oral rehydration salts rather than antidiarrhoeal drugs. The *International Confederation of Midwives* has asked 80,000 members in 42 nations to become actively involved in reducing maternal mortality rates and in putting today's child-care knowledge at the disposal of new parents.

These efforts, too, are only a small beginning. But they are enough to show that if far larger numbers of health professionals were to become actively involved in this cause, then some of the most basic of health goals would be drawn within reach.

Educators

A third occupational group which could, in most countries, make a significant and specific contribution to this cause is the education profession.

For all the problems of underfunding of schools and inadequate equipment, there are still at least five times as many teachers as there are health workers in the developing world, and the formal education system is by far the broadest channel for the dissemination of the new knowledge in which so much of the present potential resides.

As with the media and the health profession, generalization is dangerous across so many different problems and priorities, countries and cultures. But a basic education, especially if it is to last for only a few years, should attempt to better equip children for the roles and responsibilities they will assume in the future. And because today's children are tomorrow's parents, and also the carriers of information to their own parents, no child should leave school without today's basic knowledge of how to protect the vulnerable years of childhood in the most effective and least expensive way.

This, too, is a specific rather than a general challenge. No child should leave school without knowing about:

- The basics of good nutrition.

- The importance of breastfeeding, the dangers of bottle-feeding (panel 13), and the special feeding needs of the young child.

- The enormous benefits of the responsible planning of family size and the well-informed timing and spacing of births.

- The importance of clean water and safe sanitation, home hygiene and disease prevention.

- The need for immunization.

- What to do about the most common illnesses - especially diarrhoeal disease and coughs and colds - and when it is essential to get help from a trained health worker.

- Basic facts about both local and global environmental issues and about what individuals and families can do to preserve the integrity of that environment.

- The principle that girls have the same basic abilities, potential, needs, and rights as boys and should have the same education, status, and opportunities.

In addition, the education profession in most countries could do more to tackle what is in many ways the most important educational problem in the world today - the high drop-out rates among those who start primary school, particularly among girls. Almost 90% of all children in the developing world now start school. But in many nations up to half drop out before completing four years and before becoming literate. Achieving the goal of a basic education for all children therefore depends in large measure on preventing this educational haemorrhage. Most of the factors behind high drop-out rates are beyond the control of schools and teachers. But an impact could be made on this problem, in some countries, if education administrators, school principals, and teachers were aware of both the many reasons for dropping out of school and of the factors in the content and organization of school life which could help to stem this flow.

Many education systems have already assumed such responsibilities - and particularly the responsibility for disseminating today's essential health information. In 1989, UNICEF, WHO, and UNESCO jointly published the *Facts for Life* booklet, which sets out, in its briefest and simplest form, the basic health information that 'every family now has a right to know'. That booklet, translated into 138 languages in over 100 countries, is now part of the national education curriculum and/or national literacy programmes in more than 30 countries.

But much more could be done if educators at all levels, including the teacher training colleges and the professional associations, were to decide to add the weight of their experience and expertise to this cause.

Practical and political help

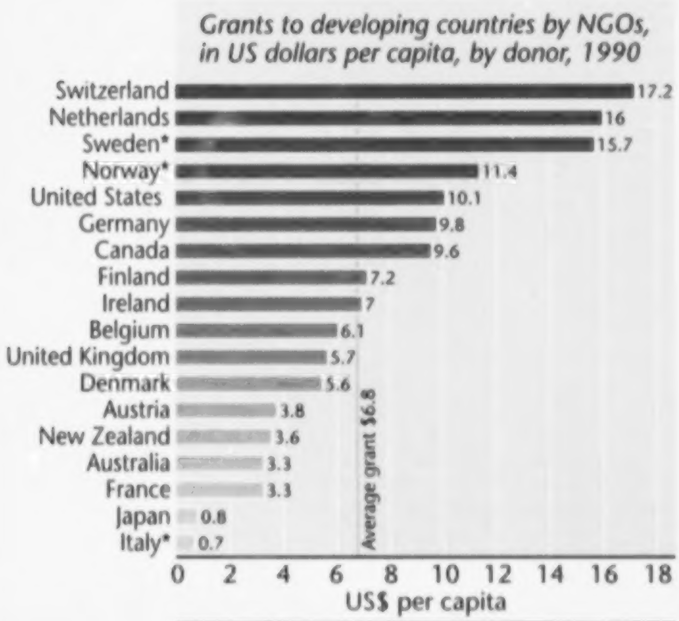
Finally, support for meeting basic human needs has long been forthcoming from a great variety of voluntary organizations in the industrialized world. The extent and importance of that support, in helping many millions of families to meet their needs and to cope with some of the greatest of human difficulties and disasters, is much underestimated. In particular, it is widely assumed that such contributions are of vastly less significance than government aid programmes. But this is a piece of conventional wisdom that is in need of reappraisal.

Voluntary organizations in the industrialized nations disburse approximately $5 billion each year in support of programmes to meet basic human needs (fig. 12).[39] Aid from the Western industrialized nations totals approximately $40 billion a year ($52 billion if multilateral aid is included). But as we have seen, the proportion of bilateral and multilateral aid allocated directly to the meeting of basic needs is approximately 10%. In other words, it is about $4 to $5 billion a year - roughly the same as the amount donated by the voluntary organizations (although in some countries a proportion of government aid is channelled through voluntary organizations).

If the quality as well as the quantity of aid is taken into account, then the balance of this comparison tilts further in the direction of the NGOs. In recent years, NGOs in the industrialized world have begun to work ever more closely with counterpart organizations in the developing world: they have also begun to offer the kind of aid programmes that meet the needs and enhance the capacities of the poor, encourage the participation of those whom they seek to assist, recognize the contribution of women, and take into account environmental factors.

Fig. 12 The NGO contribution

Voluntary organizations contribute about $5 billion a year to projects in the developing world – more than the 'basic needs' component of the aid given by governments (bilateral). The chart shows contributions per person from the industrialized world.



* Figures are for 1989.

Source: OECD unpublished data.

The overall contribution of voluntary movements in the industrialized world is therefore far from insignificant in this struggle.

It nonetheless remains true that at present the voluntary organizations are not nearly strong enough, in either practical or political impact, to take full advantage of the present potential. Such organizations can count on the support of hundreds of thousands of people. They need to be able to count on the support of millions. A different order of participation must now be sought.

At the fund-raising level, it may be that the voluntary organizations will respond to the direct challenge of the additional $8 billion which is required as the industrialized world's share of a new effort to overcome the worst aspects of poverty in the decade ahead. That target could almost be achieved by a doubling of the industrialized world's voluntary contributions - an increase which would be both a significant practical contribution towards reaching basic social goals and a sign of growing public support for this cause.

At the political level, a strengthening of the NGO movement could make an even more crucial contribution to the meeting of basic needs. Only increased public pressure can make the meeting of basic needs into a lasting national and international priority. But it is not only pressure for more aid that is required. More and more voluntary organizations are taking on the responsibility of drawing public attention to the deeply entrenched injustices in economic relationships between developing and industrialized nations. This year, for example, 20 of the best-known voluntary agencies in 13 European countries have jointly lobbied for further action on the debt crisis that continues to have such a devastating effect on lives and livelihoods in the developing world.[40]

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Maternal deaths: emergency care

Every year an estimated 500,000 women die from the complications of being pregnant and giving birth. Ninety-nine per cent of these deaths happen in the developing world. In Africa, a woman's chances of dying in pregnancy or childbirth are approximately 1 in 20; in Asia the risk is 1 in 54, in Latin America 1 in 73, in northern Europe 1 in 10,000.

The 1990 *World Summit for Children* called for a reduction in maternal deaths of at least 50% by the year 2000, and many nations are now beginning to look for ways and means of achieving this target.

There are only three options - preventing unwanted pregnancies, preventing obstetric complications, and preventing deaths when complications do occur.

The first option offers vast scope. Approximately one third of all pregnancies in the developing world are unwanted. And as most unwanted births fall into the high-risk category, family planning could therefore prevent a disproportionately large number of maternal deaths. It would also reduce the toll of unsafe abortion, which now claims the lives of over 100,000 young women each year.

Family planning also plays a part in the second option - preventing complications arising. One quarter to one third of all maternal deaths occur when births are too many in total (more than four) or to mothers who are too young (under 18) or too old (over 35).

Contrary to the hopes of many, it does not now seem that there is any means of very significantly reducing the risks of complications once a woman has become pregnant. Even improvements in nutrition and general health have relatively little effect. In the United Kingdom and the United States, for example, maternal mortality remained at very high levels even after improvements in nutrition and health had helped reduce infant mortality to very low levels. Only in the 1930s, when emergency obstetric care became widely available, did maternal mortality begin its steep fall. Even today, there is a religious community in the United States whose maternal mortality rate is similar to that of India - and about 100 times higher than the US average - despite high levels of income, education, nutrition and health care. The reason? Its members refuse modern medical services, even in emergencies.

At one time, it was thought that the problem could be reduced by early identification of those women likely to suffer complications in childbirth so that they could be moved to, or near, a modern maternity unit. At least two visits to a health centre and immunization against tetanus are essential during pregnancy. But recent findings indicate that in approximately 50% of obstetric emergencies there is no obvious risk factor which can be observed or acted on earlier in the pregnancy.

In other words, reducing maternal mortality depends in large measure on providing emergency obstetric care. This does not necessarily mean high-tech hospitals in cities. Such care can be provided in small maternity units and health centres. But even then it will not be available to those most in need unless problems in childbirth are quickly recognized and preparations made for an immediate move to a maternity unit. To achieve that, every father-to-be should make arrangements - in advance - for transport to a hospital or maternity unit should the need arise.

In all countries, it is essential for individuals and organizations involved in this cause to be aware also of the mistakes and injustices which governments alone can correct and which profoundly affect the efforts of millions of people to meet their basic needs. And it is to a brief consideration of these wider issues that the last chapter of this report now turns.

The wider context

There is still room for hope that the changes occurring in the political and economic landscape as the world emerges from its political ice age may be creating more favourable conditions for a successful advance against the worst aspects of poverty.

The collapse of the Soviet Union, and of faith in monolithic politics and highly centralized economic systems, has ended the cold war and opened up new possibilities for disarmament, for economic reform, and for the advance of democracy. If realized, all of these possibilities would further the cause of meeting basic needs.

First, the end of the cold war has made possible a reduction in that vast share of the world's resources - physical, financial, scientific, managerial - that has for so long been devoted to war and to military repression. It has therefore raised hopes that a greater share of such resources might become available for alleviating some of the great social problems facing the nations of the industrialized world; for halting and reversing the damage that is being done to the environment; and for investing in the eradication of poverty and the achievement of sustainable economic growth in the developing world.

At the moment, all this remains on the shelf of potential.

In the industrialized world, military spending has largely withstood the geopolitical earthquake that has occurred. Overall, military expenditures stand at approximately $750 billion a year - the equivalent of the combined annual incomes of the poorest half of the world's people.[41] In real terms, the United States is spending approximately 50% more on defence today than it was a decade ago. Projected spending, in the five-year defence programme presented to the U.S. Congress in January 1992, envisages a decline so gradual that expenditures in 1996 will still be 25% higher, in constant dollars, than they were in the era of Nixon and Brezhnev.[42] Similarly, in Western Europe, where the political and military situation has been utterly transformed in the last five years, there has been much talk of defence cuts but no noticeable decline in the level of military spending.[43]

In the developing world, the reduction in military spending in the six years from 1984 to 1990 has amounted to approximately 20%. But this figure, too, proves a hollow prop for optimism. Almost all of that reduction has occurred in the Middle East. In other regions, there have been few really significant reductions and most of the cuts that have been made are a result more of a compulsion to service debts rather than of a commitment to meet basic needs.

Nonetheless, change is surely in the air for some of the poorest and most militarized nations of the world where the cold war has for so long take a heavy toll. In Ethiopia, for example, where half a million soldiers have been demobilized in the last year, the military's share of total government expenditure has fallen from almost 60% to just over 30%, and spending on health and education has risen from 12% in 1989/90 to almost 20% in 1992/93. Meanwhile the first anniversary of the new government was celebrated with a parade not of troops and traditional military hardware but of people bearing olive branches and waving flags on which were emblazoned the white doves of peace.

Demilitarization

If the diversion of funds from defence to development remains mainly a matter of potential, the ending of the cold war has already begun to help the cause of the world's poor in other ways.

Chief among those ways is the substantial progress that has already been made, in many nations, towards the demilitarization and democratization of society. For the days are now gone when military dictatorships could derive political legitimacy, military equipment, and economic aid, merely by saluting the ideological flag of one or other of the two superpowers.

In this sense, the significance of the ending of the cold war can hardly be exaggerated. Forty years of cold war rivalry has contributed to the militarization of political cultures in many developing nations, helping to fertilize the weeds of dictatorship and to seed new tyrannies. The result has been a waste of resources on an extraordinary scale. Military spending in the developing world has quintupled, in real terms, in only 30 years.[44] And over much of that time, militarized élites have governed for the benefit of the few, used their weapons more often against their own citizens than against foreign aggressors, and succeeded only in denying people their rights without meeting their needs. In addition, the people of the developing world have also had to pay the cost of the military culture in the coinage of war itself. And no one has paid a higher price than their children. In the last decade alone, more than 1.5 million children have been killed in wars, more than 4 million have been physically disabled, more than 5 million have been forced into refugee camps and more than 12 million have lost their homes.[45]

The effect of all this on progress towards meeting basic human needs has been predictably devastating. The famines and deprivations endured in recent years in such countries as Chad, Ethiopia, Liberia, Mozambique, Somalia, the Sudan, and Uganda have all been either caused or exacerbated by military conflict. Crops, roads, markets, schools and clinics have been destroyed; trade and commerce, and the very means of earning a living, have been disrupted; civil liberties have been crushed along with the hopes of millions of people for a minimally decent life.

To some of the victims of this long-running tragedy, the ending of the cold war has brought new turmoil and new devastation. To others, it has brought new hope. In the last three years alone, over a third of the world's nations have changed the course of their political development in the direction of democracy.

This is good news for a movement to meet basic human needs in the years ahead. For the more progress that is made towards democracy, the more the poorest groups in society will begin to exercise a degree of political influence.

Finally, the advance of political and press freedoms can also help to create the kind of environment in which people and their organizations can work for the changes that will enable them to meet their own needs. In an already quoted analysis, Amartya Sen has argued this case - that political and press freedoms are central, not incidental, to the cause of meeting human needs - in relation to the more specific question of ending hunger and malnutrition. It is an argument that applies just as well to the struggle for better health or education:

"*Democracy and an uncensored press can spread the penalty of famines from the destitute to those in authority; there is no surer way of making the government responsive to the suffering of famine victims.*

"*However, while democracy is a major step in the right direction, a democratic form of government is not in itself a sufficient guarantee for adequate public activism against hunger. For example, in India the issue of famines has been thoroughly politicized, helping to eliminate the phenomenon, but the quiet continuation of endemic undernourishment and deprivation has not yet become correspondingly prominent in the news media and in adversarial politics. The same can be said about gender bias and the greater relative deprivation of women. The political incentives to deal with these major failures would enormously increase if these issues were to be brought into political and journalistic focus, making greater use of the democratic framework.*

"*... public action has to be seen as actions by the public and not just as state actions for the public. To eliminate the problem of hunger, the political framework of democratic and uncensored press can make a substantial contribution, but it also calls for activism of the public. Ultimately, the effectiveness of public action depends not only on legislation, but also on the force and vigour of democratic practice.*"[46]

Redirecting aid

The ending of the cold war may also further this cause by redirecting aid away from some of those countries that blatantly attach far greater priority to military spending than to meeting human needs.

Aid to overmilitarized economies is ceasing to be perceived as essential to the foreign policies of donor nations. And as there is little support among the tax-payers of the industrialized world for helping to finance the purchase of weapons and the waging of wars in the developing world, it is likely that aid will increasingly begin to flow according to the new contours of the post-cold war period.

At a meeting of 18 donor nations in Paris in December 1991, it was agreed in principle that reduced arms spending and progress towards democracy should become important criteria for the allocation of aid in the 1990s. Germany has already announced a 25% cut in aid to India because of "excessive armaments". Japan has informed the Democratic People's Republic of Korea that there will be no consideration of either aid or credits until all nuclear facilities are opened for international inspection. And the Independent Group on Financial Flows to Developing Countries (IGFFDC) - chaired by former German Chancellor Helmut Schmidt and including the former Presidents or Prime Ministers of Canada, Nigeria, Peru and the Republic of Korea - has recommended that the future allocation of aid and loans should favour those countries which spend less than 2% of GDP on military capacity. The main aid-giving countries are also, of course, among the main arms-selling countries, and it

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The Bamako Initiative: a people's health service

Most of the money spent on health in the developing world comes not from government or from international aid but from people's own pockets. Even in the poorest countries, between 5% and 10% of family incomes is regularly spent on fees to doctors, clinics, traditional healers, mission hospitals, private pharmacists, and druggists of variable repute.

In other words, most people have alternatives when it comes to health care. And in many countries, government health services are becoming increasingly unpopular. Spending cuts induced by debt, falling export prices and military spending have meant unpaid salaries, demoralized health workers and bare shelves. There is also widespread discontent at the rudeness and poor service on offer in government clinics.

As a result, private pharmacists and unqualified druggists have taken over the role of primary providers of health care in many regions. Often this means exorbitant prices for treatments and drugs that are frequently unnecessary and sometimes harmful.

In September 1987, the Ministers of Health of most African governments discussed with WHO and UNICEF an entirely new approach to this problem. The result was the launching of the Bamako Initiative. Its aim was to transform the 40,000 government health facilities in sub-Saharan Africa into a new kind of health service which would in large part be controlled by, and responsible to, the communities it was intended to serve.

With little or no additional money available from government, an improved service could only be financed by relying on people's proven willingness to pay for health care. At the same time, it was acknowledged that people would only be willing to pay if government health services began giving them what they want - a sympathetic and competent health worker and a reliable supply of the most essential medicines at prices they can afford.

Initially, international aid was used to make sure that health workers were adequately trained and that all the health centres in the scheme were well stocked with generic drugs, bought in bulk at very low cost. The drugs are sold at a profit while still costing much less than the same products bought privately. The revenues generated come under the control of the community through a local management committee.

Despite all doubts that such a scheme could succeed in the face of Africa's difficulties, the Bamako Initiative is working. So far nearly 2,000 government health centres - covering about 20 million people - have been revitalized by going over to the new system. In 1992, an evaluation by the London School of Hygiene and Tropical Medicine concluded that, although there are many problems, local communities are proving to be both competent in the local management of health care funds and in their distribution of essential drugs. About half of all revenue so far has been spent on replenishing drug supplies. Another quarter has been used to run the health centres and provide incentives for health workers. The remainder has been kept as savings.

The most commonly voiced doubt has been that charging fees might exclude the poorest. But after exploring that particular concern in Cameroon, a separate study has concluded that the new system is bringing significant benefits to the poorest 20% who could not afford the prices charged by private druggists but who could afford the much cheaper prices of the new-style health centres.

"*The overall conclusion*," says the London School evaluation, "*is that much looks promising. UNICEF and other agencies should continue to support countries' efforts to implement the Bamako Initiative and the need for substantial investment in this process should be recognized.*"

remains to be seen whether a similar stand on principle will be taken in relation to weapons sales to the developing world.

In a separate proposal, former World Bank President Robert McNamara has supported the IGFFDC recommendation as part of a plan to reduce arms spending in both industrialized and developing worlds. The plan envisages Security Council guarantees of territorial integrity, continued reductions in conventional and nuclear weapons in industrialized countries (including a 50% cut in United States' arms spending over the next six to eight years), tighter controls on the proliferation of nuclear weapons, new limitations on arms exports, and the tying of international aid to progress towards a 50% cut in military expenditures (as a percentage of GNP) by the end of this century.[47]

Needless to say, any such reductions would, if implemented, be capable of paying many times over for the effort to meet basic human needs.

Aid for basic needs

In the industrialized world, those who support progress towards meeting basic human needs should also be aware that increases in aid are not enough. Two other changes are needed.

First, as has already been discussed in Part I, the proportion of aid given for the purposes of directly meeting the basic needs of the poor should be increased to at least 20%.

Second, the flow and direction of aid should also be influenced by whether or not aid is likely to be used to bring additional benefits to the poorest quarter of the recipient countries' populations (as opposed to providing services for the not-so-poor or allowing governments to spend more of their own resources on prestige projects or on the military). One way of assessing that likelihood is by regularly monitoring progress towards the agreed basic needs goals.

Far from being too idealistic a notion, the idea that the flow of aid and loans should be heavily influenced by the likelihood of their being used to meet basic needs is an idea currently being considered by the institution that is the world's largest source of development finance. In October 1991, the President of the World Bank told the annual meeting of the International Monetary Fund/World Bank that poverty eradication should be the Bank's "*overarching objective*" and that the volume of Bank lending "*should be linked to efforts to reduce poverty*."[48]

The evolution of such new criteria for aid and loans could both assist, and be assisted by, a greater public concern for aid in the industrialized world. Public support for aid is not dead. But it has been seriously wounded by the widespread and largely justified perception that aid is not primarily being used to meet the needs or enhance the capacities of the poorest, or to directly attack the worst aspects of poverty. Mobilizing public support for increases in aid therefore depends, in large part, on making aid programmes themselves more worthy of that support. And that responsibility is one which sits on both 'donor' industrialized nations and 'recipient' developing nations with equal weight.

International trade

In addition to the potential reductions in military spending and the actual advances made by democracy, the collapse of the Soviet Union and the end of the cold war have also led to economic reform and to the adoption of 'market-friendly' policies in many countries that have long laboured under highly centralized economic regimes. The result is likely to be the demise of inefficient state-owned companies, more productive use of resources, and the liberation of people's energies and initiatives. This development, too, therefore holds out the hope of accelerated economic growth.

Yet for many nations, it may well prove a false hope. Market forces cannot conjure economic growth out of an investment vacuum. The developing world needs investment: in its peoples' health and education; in the infrastructure of transport, communications, and energy; and in its industrial enterprises. Yet large parts of the developing world, and especially the nations of sub-Saharan Africa, are unable to make that investment. And the cause is not only high levels of military spending.

This year, the developing world must devote 20% of all its export earnings to servicing its debts. Those debts now total almost $1,300 billion. Each year, capital and interest repayments of $143 billion fall due.[49] Such a sum - three times as much as all the aid received from all sources - cannot of course be repaid. The unpaid part is therefore added to the total debt.

Sub-Saharan Africa is particularly hard hit. Its total debt has tripled since 1980 and now stands at approximately $175 billion. This is less than 14% of the total debt of the developing world, but it is too much for Africa's frail economies to bear. The countries of sub-Saharan Africa are now spending 50% more on the servicing of their debts than on the health and education of their children. Yet even this sacrifice is only enabling those countries to pay about one third of the interest that falls due each year.

Investment in the future is therefore being undermined by the debts of the past. And without such investment, the coming of market-friendly economic policies is unlikely to fulfil the hopes that have been aroused for accelerated economic growth.

There has been much talk of cancelling or writing down debts, and numerous proposals have been debated and adopted at meetings from Toronto to Trinidad. Yet actual debt cancellations so far have reduced sub-Saharan Africa's annual payments by approximately $200 million per year on total 1991 payments of $10.6 billion a year - a reduction of approximately 2%.[50]

Instead, the policy that has been consistently urged on debtor nations is that they should increase their exports in order to earn their way out of debt. But because the developing world is still so dependent on a relatively small range of raw materials for its export earnings (Latin America remains two-thirds dependent on raw materials and Africa over 90%) the result has been an over-supply and a further collapse in prices. Côte d'Ivoire and Ghana have boosted exports of cocoa. Tanzania has boosted exports of cotton. But to no avail. Prices for the developing world's principal raw materials, which fell steadily in the 1980s, fell by another 20% between 1989 and 1991[51] and are likely to remain at this depressed level for the foreseeable future.[52] This solution has therefore conferred its main benefits on the industrialized nations in the form of cheaper commodities. Meanwhile, for the developing world, the debts have continued to mount.

The obvious answer is for developing nations to diversify their economies and begin exporting processed and manufactured goods in order to reduce dependence on commodities and to earn foreign exchange. But this requires both investment and access to markets. And in large measure, both of these are being denied to most of the countries of the developing world today. Investment from internal resources is, as we have seen, largely pre-empted by military spending and debt repayments. Investments and loans from outside have almost ceased as more than $100 billion has gone to Eastern Europe, to the task of easing Russia's re-entry into the world economy, and to reconstruction in the Persian Gulf. Bilateral aid stagnates. Private investment flows almost entirely to other industrialized countries or to a handful of nations in East Asia or Latin America.

Some developing countries are now beginning to acquire the technologies that, together with the advantages of low-cost labour and abundant raw materials, could enable them to increase exports and create the jobs and the incomes by which people can meet their needs. But that opportunity is being denied to them by the tariffs, quotas, and other restrictions imposed by the industrialized nations. Such barriers are today costing the developing world approximately $50 billion a year in lost earnings - as much as all the aid they receive.[53] It is therefore also essential that the present round of discussions under the General Agreement on Tariffs and Trade (GATT) should reach the kind of agreement which will mean that economic opportunity is no longer restricted by the protectionism of those who have for so long preached free-market economics to the developing world.

Optimism at the spread of market-friendly economic policies must therefore be tempered by the fact that the rules of the international market-place are not neutral but are often heavily biased against the developing world. And those who seek to support the basic needs movement must also be aware that pressure for action on debt, aid and loans, and on trading relationships, will also be a necessary part of that struggle.

The market and the poor

For those who are involved or who may become involved in such a movement, it is also important to be aware that economic growth, even if achieved, does not in itself mean that basic needs will be met. In a great many countries today, including many industrialized nations and many developing nations that have enjoyed rapid economic growth in the past, the poorest 20% have not shared in the benefits of that growth. In the United Kingdom and the United States, for example, the 1980s were years of almost continuous economic growth in which the poorest of their peoples have shared not at all.[54]

The recent return to growth in Latin America also illustrates the point. Economic reform in the late 1980s and early 1990s has helped to push GNP growth beyond 3% a year in Latin America as a whole. But in a nation such as Brazil, where the income of the richest 20% is 33 times greater than that of the poorest 20%, the benefits of a return to economic growth are shared so unequally that the poorest derive little or no benefit from the process. Similarly in Venezuela, where economic growth touched 9% in 1991, the very poorest families have seen little improvement in their standard of living and many have found that the cost of meeting their basic needs has risen faster than their incomes.[55]

The links between economic reform, economic growth, and the meeting of basic needs are therefore anything but automatic. Specific government policies are not only necessary to

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CIS: a stitch in time

In 1992, UNICEF and WHO led a United Nations fact-finding mission to 14 nations of the former Soviet Union. The result is a report about a human crisis in the making and a recommendation that aid to help maintain essential services now could avoid the need for much greater outside help in the future. In response, the UNICEF Executive Board has requested that plans be drawn up for the opening of new UNICEF offices in Armenia, Azerbaijan, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan.

Throughout the 1980s, UNICEF has argued that it makes both economic sense and human sense to protect young children from the worst effects of the mistakes and misadventures of the adult world. The growing minds and bodies of the young can suffer permanent consequences from even temporary deprivation. So no matter how difficult the circumstances, it is essential to protect the health, nutrition and education of the young if the problems are not to be perpetuated into the next generation.

In the new nations of the former Soviet Union, the basic infrastructure still exists to ensure that those minimum services are available to the 25 million children under the age of five who represent their nations' future.

Unlike many developing countries, the new nations of the Commonwealth of Independent States (CIS) began life with near-universal literacy and a vast network of schools and health posts. Immunization coverage probably exceeded 90% in the last years of the USSR, and the ratio of medical facilities to population was one of the highest in the world. Kazakhstan, for example, has 7,640 health centres and 278 hospitals for 16.5 million people.

But by 1992 that infrastructure was threatened with breakdown. In most of the republics, health budgets are now fulfilling only one third of estimated requirements. Vaccine production has all but ceased, and disruptions to trade and payment systems mean that all Ministries of Health are reporting severe shortages of essential drugs and equipment. High food costs and lack of supplies threaten pre-school and primary school feeding programmes and particularly the network of free milk kitchens which serve roughly half of all children under the age of three. In addition, a squeeze on public finance is rapidly eroding social support mechanisms such as pensions and child benefits.

The prospect of hunger also threatens many of the 200 million inhabitants of the CIS. Price liberalization and trade disruption drove up food prices by as much as seven times in the first month of 1992 alone. Wages have not kept pace. In the Russian Federation, household incomes increased threefold in 1991 while the price of meat and vegetables rose ninefold. Many families coped by using hoarded food, but now millions are missing meals and eating dinners of bread and potatoes.

All of these problems are compounded by environmental tragedy. Russian environmental experts say that 17% of the former Soviet Union - home to a quarter of its population - now qualifies as an ecological crisis area. Almost a quarter of all children born in such areas are reported to have genetic abnormalities.

Poverty in the former Soviet republics is not yet on the same scale or of the same severity as is to be found in the developing world. But the situation is rapidly worsening. In 1989, official figures showed 11% of families across the Soviet Union living below the poverty line; in many regions today, over three quarters of the population has fallen into poverty.

promote the right kind of growth but also to translate that growth into improvements in the lives of the disadvantaged. Market economics is not a panacea for social progress. And if governments abandon their responsibilities, then the result will be societies in which inequalities continue to increase and in which economic demand counts for all and human need counts for nothing. It is the responsibility of government to support parents by investing in health and education for all children; to construct the safety nets which will mean that the minimum needs of the vulnerable are met; to make available to all the basic benefits of advances in human knowledge that are of little commercial interest; and to offset the inbuilt tendency of market forces to favour the already advantaged. Basic needs will not be met, and basic investments will not be made, by any invisible hand.

The end of the cold war, the collapse of Soviet communism, the widespread movement towards political democracy and economic reform, have raised a worldwide hope that this century could end as optimistically as it began disastrously. It is an unprecedented opportunity which has so suddenly been presented. But it is no more than that - an opportunity - and it will not remain open forever. And it is now essential that the industrialized nations that have urged democratic politics and free-market economics on the developing world should now do everything in their power to create the international environment in which such policies can prove themselves.

If this can be done, then the economic and political reforms now being so widely implemented could engender the kind of progress from which the poor might also derive some benefit. By the advance of democracy, the poorest classes could begin to acquire a little more of the political influence which, in most cases, is the missing link between what could be done and what is being done to eradicate the worst of poverty; and by economic reform, increasing numbers of the poor should be able to meet their own needs by means of their own efforts and their own incomes.

Conclusion

In 1992, many specific tragedies have again assaulted the very idea of childhood in such places as Somalia and the former Yugoslavia. The response to these tragedies, wherever they occur, is a major part of the work of UNICEF and is addressed in many other UNICEF publications and statements during the course of the year.

But for more than 10 years, the *State of the World's Children* report has concentrated on those issues which profoundly affect far larger numbers of children but which are so constant in time and so diffuse in place that they do not at any one time constitute the kind of news event which qualifies for the world's attention.

That tragedy, however invisible and unnoticed, is far greater in scale than even the greatest of the emergencies which so often command the world's, and UNICEF's, concern. No famine, no flood, no earthquake, no war, has ever claimed the lives of 250,000 children in a single week. Yet malnutrition and disease claim that number of child victims *every week*. And for every one of those children who dies, many more live on with such ill health and poor growth that they will never grow to the physical and mental potential with which they were born.

When little or nothing could be done about this larger-scale tragedy, then neglect was perhaps understandable. But slowly, quietly, and without the world taking very much notice, we have arrived at the point where this tragedy is no longer necessary. It is therefore no longer acceptable in a world with any claim on civilization. The time has therefore come for a new age of concern.

Political and economic change in the world is beginning to create the conditions which, however difficult, offer new hope for overcoming the worst aspects of world poverty, particularly as they affect the world's children. The cost of providing health and education services in the developing world remains relatively low, and the gradual stabilization in the numbers of infants being born means that further investments in basic services can now begin to increase the proportion of the population served. Meanwhile, the technologies and strategies for controlling malnutrition, disease and illiteracy have been tried and tested and now stand waiting to go into action on the same scale as the problems they can so largely solve.

The convergence of all of these different forces means it is now possible to achieve one of the greatest goals that humanity could ever set for itself - the goal of adequate food, clean water, safe sanitation, primary health care, family planning, and basic education, for virtually every man, woman and child on earth.

In 1990, this new potential for specific action against these worst aspects of poverty was formulated into a set of basic social goals which accurately reflect that potential and which have been formally accepted by the great majority of the world's political leaders. A start has been made, in many nations, towards keeping the promise of those goals.

We therefore stand on the edge of a new era of concern for the silent and invisible tragedy that poverty inflicts on today's children and on tomorrow's world. Whether the world will enter decisively into that new age depends on the pressure that is brought to bear by politicians, press, public, and professional services in all nations.

Such pressure will not be easy either to create or to sustain. A movement to overcome the worst aspects of poverty, and particularly to protect children, has no obviously powerful constituency and no immediate vested interest to appeal to. The environmental and women's movements are, in varying degrees, becoming everyone's concern, for the obvious reason that almost everyone is directly touched in one way or another by both of these issues. In scale and in severity, the tragedy of malnutrition, disease, and illiteracy should touch hearts and minds as powerfully as those tragedies which, by virtue of being 'events', have the power to shock the world and to elicit the feelings of human solidarity on which all civilization depends. But in addition to that instinctive response, the more complex realities of common cause must also become more widely known and understood. A movement to meet basic needs will not succeed unless it, too, becomes everyone's concern.

Making common cause is not a question of marginal mutual support. None of the great issues that are assuming priority today - the cause of slowing population growth, the cause of achieving equality for women, the cause of environmentally sustainable development, the cause of political democracy - will or can be realized unless the most basic human needs of the forgotten quarter of the earth's people are met. This cause, too, must therefore become the concern of all. And among readers of the present report, there is hardly any individual or organization that could not now become involved. □

The year 2000: what can be achieved?

The following is the full list of goals, to be attained by the year 2000, which were adopted by the *World Summit for Children* on 30 September 1990.

Overall goals 1990-2000

○ A one-third reduction in under-five death rates (or a reduction to below 70 per 1,000 live births - whichever is lower).

○ A halving of maternal mortality rates.

○ A halving of severe and moderate malnutrition among the world's under-fives.

○ Safe water and sanitation for all families.

○ Basic education for all children and completion of primary education by at least 80%.

○ A halving of the adult illiteracy rate and the achievement of equal educational opportunity for males and females.

○ Protection for the many millions of children in especially difficult circumstances and the acceptance and observance, in all countries, of the recently adopted *Convention on the Rights of the Child*. In particular, the 1990s should see rapidly growing acceptance of the idea of special protection for children in time of war.

Protection for girls and women

○ Family planning education and services to be made available to all couples to empower them to prevent unwanted pregnancies and births which are 'too many and too close' and to women who are 'too young or too old'. Such services should be adapted to each country's cultural, religious, and social traditions.

○ All women to have access to prenatal care, a trained attendant during childbirth and referral facilities for high-risk pregnancies and obstetric emergencies.

○ Universal recognition of the special health and nutritional needs of females during early childhood, adolescence, pregnancy, and lactation.

Nutrition

○ A reduction in the incidence of low birth weight (under 2.5 kg.) to less than 10%.

○ A one-third reduction in iron deficiency anaemia among women.

○ Virtual elimination of vitamin A deficiency and iodine deficiency disorders.

○ All families to know the importance of supporting women in the task of exclusive breastfeeding for the first four to six months of a child's life.

○ Growth monitoring and promotion to be institutionalized in all countries.

○ Dissemination of knowledge to enable all families to ensure household food security.

Child health

○ The eradication of polio.

○ The elimination of neonatal tetanus (by 1995).

○ A 90% reduction in measles cases and a 95% reduction in measles deaths, compared to pre-immunization levels.

○ Achievement and maintenance of at least 90% immunization coverage of one-year-old children and universal tetanus immunization for women in the child-bearing years.

○ A halving of child deaths caused by diarrhoea and a 25% reduction in the incidence of diarrhoeal diseases.

○ A one-third reduction in child deaths caused by acute respiratory infections.

○ The elimination of guinea worm disease.

Education

○ In addition to the expansion of primary school education and its equivalents, today's essential knowledge and life skills could be put at the disposal of all families by mobilizing today's vastly increased communications capacity.

A progress report

Following the 1990 *World Summit for Children*, most countries agreed to draw up *national programmes of action* (NPAs) for achieving basic social goals. Those goals include control of the major childhood diseases, a halving of child malnutrition, a one-third reduction in under-five death rates, a halving of maternal mortality rates, the provision of safe water to all communities, the universal availability of family planning information and services, and a basic education for all children. The table below shows the status of these NPAs, in each country, as of September 1992.

The *Summit* also urged all countries to ratify the *Convention on the Rights of the Child*, which seeks to lay down minimum standards for the survival, protection, and development of all children. Approximately 120 nations have so far done so. Their names are printed in colour in the table below.

○ = Declaration of the World Summit for Children Signed (139)
● = National programme of action in preparation (46)
● = National programme of action in draft form received (34)
● = National programme of action finalized (54)

Countries printed in colour have ratified the *Convention on the Rights of the Child* (122)

Afghanistan				
Albania	○			
Algeria			●	
Angola		●		
Antigua & Barbuda	○			
Argentina	○		●	
Armenia				
Australia	○		●	
Austria	○			
Azerbaijan				
Bahamas				
Bahrain		●		
Bangladesh	○			●
Barbados	○	●		
Belarus	○	●		
Belgium	○			●
Belize	○			●
Benin	○	●		
Bhutan	○		●	
Bolivia	○			●
Bosnia & Herzegovina				
Botswana	○	●		
Brazil	○		●	
Brunei				
Bulgaria	○			
Burkina Faso	○		●	
Burundi	○		●	
Cambodia				
Cameroon	○		●	
Canada	○			●
Cape Verde	○	●		
Central African Rep.	○			●
Chad	○		●	
Chile	○		●	
China	○			●
Colombia	○			●
Comoros	○	●		
Cook Islands		●		
Congo	○	●		
Costa Rica	○			●
Côte D'Ivoire	○		●	
Croatia				
Cuba	○			●
Cyprus				
Czechoslovakia (former)	○			
Denmark	○			●
Djibouti	○			●
Dominica	○			
Dominican Rep.	○			●
Ecuador	○			●
Egypt	○			●
El Salvador	○			●
Estonia				
Ethiopia		●		
Fiji			●	
Finland	○			●
France	○	●		
Gabon	○			
Gambia	○		●	
Germany	○			●
Ghana	○			●
Grenada	○			
Greece				
Guatemala	○			●
Guinea	○			●
Guinea-Bissau	○	●		
Guinea Equatorial	○		●	
Guyana	○	●		
Haiti				
Holy See	○			●

Honduras	○			●
Hungary	○			
Iceland	○			
India	○		●	
Indonesia	○			●
Iran	○			●
Iraq				
Ireland	○			
Israel	○			
Italy	○	◍		
Jamaica	○			●
Japan	○			●
Jordan	○		●	
Kazakhstan	○			
Kenya	○			●
Kiribati		◍		
Korea Dem. Peo. Rep.	○		●	
Korea Rep. of	○			●
Kyrgyzstan				
Kuwait	○	◍		
Lao Peo. Dem. Rep.	○			
Latvia				
Lebanon	○	◍		
Lesotho	○	◍		
Liechtenstein	○			
Liberia				
Libya			●	
Lithuania				
Luxembourg	○			
Madagascar	○	◍		
Malawi	○	◍		
Malaysia	○		●	
Maldives	○		●	
Mali	○			●
Malta				
Marshall Islands				●
Mauritania	○		●	
Mauritius	○	◍		
Mexico	○			●
Micronesia		◍		
Monaco	○			
Mongolia	○	◍		
Moldova				
Morocco	○			●
Mozambique	○		●	
Myanmar		◍		
Namibia	○			●
Nepal	○			●
Netherlands	○			●
New Zealand	○	◍		
Nicaragua	○			●
Niger	○		●	
Nigeria	○		●	
Norway	○			●
Oman		◍		
Pakistan	○			●
Panama	○			●
Papua New Guinea	○	◍		
Paraguay	○			●
Peru	○			●
Philippines	○			●
Poland	○			
Portugal	○	◍		
Qatar		◍		
Romania	○			
Russia	○			
Rwanda	○		●	
Samoa	○			
St. Kitts & Nevis	○	◍		
St. Lucia	○	◍		
St. Vincent & Grenadines	○	◍		
San Marino				
Sao Tome & Principe	○		●	
Saudi Arabia		◍		
Senegal	○			●
Seychelles		◍		
Sierra Leone	○	◍		
Singapore				●
Slovenia				
Solomon Islands	○	◍		
Somalia				
South Africa				
Spain	○		●	
Sri Lanka	○			●
Sudan	○			●
Suriname	○	◍		
Swaziland	○		●	
Sweden	○			●
Switzerland	○			
Syria		◍		
Tajikistan				
Tanzania	○		●	
Thailand	○		●	
Togo	○	◍		
Trinidad & Tobago	○	◍		
Tunisia	○			●
Turkey	○			●
Turkmenistan				
Tuvalu		◍		
Uganda	○		●	
Ukraine	○			
United Arab Emirates		◍		
United Kingdom	○			●
Uruguay	○			●
U.S.A.	○	◍		
Uzbekistan				
Vanuatu	○	◍		
Venezuela	○			●
Viet Nam	○			●
Yemen	○		●	
Yugoslavia (former)	○			
Zaire	○	◍		
Zambia	○		●	
Zimbabwe	○		●	

References

1 United Nations Children's Fund, *Children and Development in the 1990s: a UNICEF sourcebook*, UNICEF, New York, 1990

2 World Bank, *World Development Report 1992*, p. 26, World Bank, Washington, D.C., 1992

3 All figures from *The Economist*, 1992

4 Derived from United Nations Development Programme, *Human Development Report 1991*, p. 41, table 3.1, UNDP, New York, 1991

5 United Nations Children's Fund, *Patterns of Government Expenditure in Developing Countries During the 1980s - the Impact on Social Services*, UNICEF, International Child Development Centre, Florence, Innocenti Economic Policy Series, Paper No. 18, 1991

6 United Nations Development Programme, *Human Development Report 1992*, p. 43, table 3.15, UNDP, New York, 1992

7 Kanda, Chiyo, 'Trends in Bilateral Official Resource Flows to Social Sectors 1985-1988', UNICEF, New York, 1990

8 UNDP, *Human Development Report 1992*, p. 43, table 3.14

United Nations, 'Implementation of General Assembly Resolution 45/217 on the World Summit for Children', report of the Secretary-General to the forty-seventh session of the General Assembly, 17 June 1992, A/47/264, United Nations, New York

9 Development Centre for the Organisation for Economic Co-operation and Development, *Development Co-operation 1991*, table 14, OECD, Paris, 1991

10 'The Maecenas Touch', p. 9 of 'A Survey of the Sports Business', *The Economist*, 25 July 1992

11 Mehrotra, Santosh, 'Immunization Coverage in an Economically Unfavourable Environment', UNICEF Planning Office, UNICEF, New York, 1992

12 'Ending Hidden Hunger', a policy conference on micronutrient malnutrition, Montreal, Canada, 10-12 October 1991. Sponsored by the Canadian Agency for International Development, the Food and Agriculture Organization of the United Nations, the United Nations Children's Fund, the United Nations Development Programme, the United States Agency for International Development, the World Bank and the World Health Organization

13 Haxton, David P., 'Defeating Iodine Deficiency with a Grain of Salt', *First Call for Children*, No. 2, pp. 8-9, April-June 1992, UNICEF, New York

14 Donaldson, Lloyd A., 'Rural Water and Health: The Challenge to Water and Sanitation Sector Professionals', *WATERfront*, No. 1, p. 3, February 1992, UNICEF, New York

15 The figures for the number of schools and pupils in the BRAC scheme are estimates for December 1992 provided in August 1992 by the Senior Programme Coordinator, UNICEF Dhaka. The figure of $18 per child is taken from *Together for Education*, published by BRAC in February 1992. See also Lowell, Catherine H., *Breaking the Cycle of Poverty - the BRAC Strategy*, Kumarian Press, 1992

16 Yambi, O. and Mlolwa, R., *Improving Nutrition in Tanzania in the 1980s: The Iringa Experience*, UNICEF, International Child Development Centre, Florence, Innocenti Occasional Papers No. 25, March 1992

Shekar, M., *The Tamil Nadu Integrated Nutrition Project: A Review*, Cornell Food and Nutritional Policy Program Report, November 1991

17 United Nations, 'Implementation of General Assembly Resolution 45/217 on the World Summit for Children'

18 These examples provided by the Nutrition Cluster and the Water and Environmental Sanitation Section of UNICEF, New York

19 Mehrotra, op. cit.

20 McKee, Neill, 'Social Mobilization: Lessons from Bangladesh', *First Call for Children*, No. 2, pp. 8-9, April-June 1992, UNICEF, New York

21 For a full discussion of growth monitoring and promotion, see 'Going for Growth', *The State of the World's Children 1987*, pp. 64-80, UNICEF, New York, 1986

22 Foreword to ul Huq, Mujibul (ed.), *Near Miracle in Bangladesh*, University Press Ltd., Dhaka, 1991

23 Gill, Walt, 'CHWs: Are National Programmes in Crisis?', *Health Policy and Planning*, Vol. 3, No. 1, pp. 1-21, Oxford University Press, 1988

24 'Let Them Eat Guns', *The Economist*, p. 99, 2 November 1991

25 Sen, Amartya, 'Public Action to Remedy Hunger', Fourth Annual Arturo Tanco Memorial Lecture, Queen Elizabeth II Conference Centre, London, 2 August 1990

26 United Nations Population Division, *World Population Prospects 1992*, United Nations, New York, 1992

Hill, Kenneth, 'Babies of the Future: Setting the Scene', School of Hygiene and Public Health, Johns Hopkins University, Baltimore

27 UNDP, *Human Development Report 1992*, p. 89

28 United Nations Children's Fund, *Patterns of Government Expenditure in Developing Countries During the 1980s*

World Bank, *World Debt Tables 1991-92*, World Bank, Washington, D.C., 1992

29 UNDP, *Human Development Report 1992*, p. 44

30 Sen, Amartya, *Poverty and Famines: An Essay on Entitlement and Deprivation*, Oxford University Press, 1981

31 For a discussion of these four factors, see 'The Population Question', *The State of the World's Children 1991*, pp. 37-47, UNICEF, New York, 1990

32 Adamson, Peter, 'Two Powerful Forces for Child Survival', *People*, Vol. 15, No. 1, pp. 3-6, 1988, International Planned Parenthood Federation, London, 1988

33 Development Centre for the Organisation for Economic Co-operation and Development, *Directory of Non-Governmental Development Organisations in OECD Member Countries*, p. 24, OECD, Paris, 1990

34 UNDP, *Human Development Report 1992*, p. 78

35 See 'Partnership in Action', UNICEF, New York, 1992

36 United Nations Children's Fund, 'World Declaration on the Survival, Protection and Development of Children' and 'Plan of Action for Implementing the World Declaration on the Survival, Protection and Development of Children in the 1990s', para. 34 (iv), *The State of the World's Children 1991*, UNICEF, New York, 1990

37 Auditor's accounts, WHO, Expanded Programme of Immunization, Geneva, 1992

38 Potts, M. and Thapa, S., *Child Survival: The Role of Family Planning*, Family Health International, North Carolina, September 1991

39 OECD, *Directory of Non-Governmental Development Organisations*

40 'Debt and Development', *EUROSTEP Newsletter*, June-July 1992, Brussels

41 Sivard, Ruth Leger, *World Military and Social Expenditures 1991*, World Priorities Inc., Washington, D.C., 1991

World Bank, *World Development Report 1992*, pp. 218-219, table 1

42 McNamara, Robert S., 'The Post Cold War World and its Implications for Military Expenditures in Developing Countries', paper prepared for the World Bank Annual Conference on Development Economics 1991, 25-26 April 1991, World Bank, Washington, D.C., 1991

43 UNDP, *Human Development Report 1992*, p. 85

44 Sivard, op. cit.

45 *Effects of Armed Conflict on Women and Children: Relief and Rehabilitation in War Situations*, Vol. 10, Issue 2-3, 1991, Rehabilitation International and UNICEF, Technical Support Programme for the United Nations Decade of Disabled Persons (1983-1992)

46 Sen, op. cit.

47 McNamara, op. cit.

48 World Bank, *Assistance Strategies to Reduce Poverty*, World Bank, Washington, D.C., 1991

49 World Bank, *World Debt Tables*

50 Ibid.

51 UNDP, *Human Development Report 1992*, p. 59

52 World Bank, *Global Economic Prospects and the Developing Countries*, World Bank, Washington, D.C., 1992

53 Ibid.

54 For the United Kingdom: 'How the Other Tenth Lives', *The Economist*, p. 29, 12 September 1992

For the United States: Johnson, C.M., Miranda, L., Sherman, A. and Weill, J.D., *Child Poverty in America*, Children's Defense Fund, 122 C Street, N.W., Washington, D.C., 20001

55 'Latin America Cheers Up', *The Economist*, pp. 12-13, 18 April 1992

II

STATISTICS

Economic and social statistics on the nations of the world, with particular reference to children's well-being.

General note on the data Explanation of symbols

INDEX TO COUNTRIES

TABLES

1: Basic indicators

U5MR ☐ IMR ☐ population ☐ births and under-five deaths ☐ GNP per capita ☐ life expectancy ☐ adult literacy ☐ school enrolment ☐ income distribution

2: Nutrition

Low birth weight ☐ breastfeeding ☐ malnutrition ☐ food production ☐ calorie intake ☐ food spending

3: Health

Access to water ☐ access to sanitation ☐ access to health services ☐ immunization of children and pregnant women ☐ ORT use

4: Education

Male and female literacy ☐ radio and television sets ☐ primary school enrolment and completion ☐ secondary school enrolment

5: Demographic indicators

Child population ☐ population growth rate ☐ crude death rate ☐ crude birth rate ☐ life expectancy ☐ fertility rate ☐ urbanization

6: Economic indicators

GNP per capita and annual growth rates ☐ inflation ☐ poverty ☐ government expenditure ☐ aid ☐ debt service

7: Women

Life expectancy ☐ literacy ☐ enrolment in school ☐ contraceptive use ☐ tetanus immunization ☐ trained attendance at births ☐ maternal mortality

8: Basic indicators on less populous countries

9: Newly independent countries

10: The rate of progress

U5MR reduction rates ☐ GNP per capita growth rates ☐ fertility reduction rates

Definitions Country groupings Main sources

General note on the data

The data provided in these tables are accompanied by definitions, sources, and explanations of symbols. Tables derived from so many sources - 12 major sources are listed in the explanatory material - will inevitably cover a wide range of data reliability. Official government data received by the responsible United Nations agency have been used whenever possible. In the many cases where there are no reliable official figures, estimates made by the responsible United Nations agency have been used. Where such internationally standardized estimates do not exist, the tables draw on other sources, particularly data received from the appropriate UNICEF field office. Where possible, only comprehensive or representative national data have been used.

The data for infant mortality rates, life expectancy, crude birth and death rates, etc. are part of the regular work on estimates and projections undertaken by the United Nations Population Division. These and other internationally produced estimates are revised periodically, which explains why some of the data will differ from those found in earlier UNICEF publications.

Results from a new and continuing project to improve the under-five mortality rate (U5MR) estimates, briefly described in the *Statistical note* (facing contents page), have been used in revising the 1991 and earlier estimates of U5MR as well as estimates of under-five deaths in 1991. New indicators, which reflect the World *Summit for Children* goals, have been included on breastfeeding (table 2) and sanitation (table 3). New demographic estimates, first released by the United Nations Population Division in July 1992, have also been incorporated in the tables. Finally, the four U5MR group summaries have been changed from medians to weighted averages, and regional summaries have been added to the end of each of tables 1 to 7 and 10.

The value of 70 under five deaths per 1000 live births used to distinguish the two higher U5MR groups of countries from the two lower groups, in tables 1 to 7 and 10, reflects the *World Summit for Children* mortality goal target. The U5MR goal aims at a reduction of the under-five mortality rate in all countries during the 1990s by one third or to 70 per 1000 live births, whichever is less. Hence, if all countries achieve the under-five mortality goal, by the end of the 1990s all countries should belong to the two lowest U5MR groups.

Major social and economic changes in Asia and Europe have led to the creation of a number of newly independent countries. But country infrastructures take time to adjust to the changed status and the currently available statistics on these newly independent countries are limited. Recognizing both the need for reporting on the situation of children and women in these countries, as well as the limited coverage of the statistics, a separate table (table 9) has been added.

Explanation of symbols

Earlier reports used median values to provide aggregate measures for country groups. These have been replaced by weighted averages. Data derived using a definition different from the standard are identified. However, unlike previous reports, no detailed footnotes have been included. Since the aim of this report is to provide a broad picture of the situation of children and women worldwide, such detailed data considerations are seen as more appropriate for coverage elsewhere.

. . Data not available

x Indicates data that refer to years or periods other than those specified in the column heading, differ from the standard definition, or refer to only part of a country.

Figures in coloured bands (U5MR groups and regional summaries) are totals or **weighted** averages.

U5MR estimates for individual countries are primarily derived from data reported by the United Nations Population Division. In some cases, these estimates may differ from the latest national figures.

Index to countries

In the following tables, countries are ranked in descending order of their estimated 1991 under-five mortality rate. The reference numbers indicating that rank are given in the alphabetical list of countries below.

Afghanistan	3
Albania	84
Algeria	68
Angola	1
Argentina	90
Australia	112
Austria	122
Bangladesh	40
Belgium	111
Benin	31
Bhutan	15
Bolivia	44
Botswana	55
Brazil	65
Bulgaria	93
Burkina Faso	14
Burundi	24
Cambodia	21
Cameroon	43
Canada	116
Central African Rep.	26
Chad	10
Chile	94
China	88
Colombia	96
Congo	47
Costa Rica	99
Cite d'Ivoire	41
Cuba	103
Czechoslovakia	104
Denmark	118
Dominican Rep.	61
Ecuador	57
Egypt	56
El Salvador	66
Ethiopia	11
Finland	127
France	120
Gabon	30
Germany	117
Ghana	38
Greece	108
Guatemala	50
Guinea	6
Guinea-Bissau	5
Haiti	37
Honduras	63
Hong Kong*	124
Hungary	100
India	42
Indonesia	54
Iran, Islamic Rep. of	67
Iraq	35
Ireland	109
Israel	105
Italy	113
Jamaica	98
Japan	128
Jordan	73
Kenya	62
Korea, Dem. Peo. Rep.	81
Korea, Rep. of	115
Kuwait	102
Lao, Peo. Dem. Rep.	32
Lebanon	74
Lesotho	36
Liberia	17
Libyan Arab Jamahiriya	48
Madagascar	28
Malawi	7
Malaysia	97
Mali	8
Mauritania	13
Mauritius	87
Mexico	79
Mongolia	58
Morocco	51
Mozambique	2
Myanmar	46
Namibia	45
Nepal	33
Netherlands	125
New Zealand	114
Nicaragua	59
Niger	9
Nigeria	20
Norway	126
Oman	78
Pakistan	39
Panama	85
Papua New Guinea	60
Paraguay	69
Peru	49
Philippines	75
Poland	101
Portugal	106
Romania	80
Rwanda	19
Saudi Arabia	77
Senegal	22
Sierra Leone	4
Singapore	110
Somalia	12
South Africa	64
Spain	123
Sri Lanka	95
Sudan	29
Sweden	129
Switzerland	119
Syria	72
Tanzania	27
Thailand	82
Togo	34
Trinidad and Tobago	91
Tunisia	70
Turkey	52
USA	107
USSR (former)	83
Uganda	18
United Arab Emirates	86
United Kingdom	121
Uruguay	89
Venezuela	76
Viet Nam	71
Yemen	23
Yugoslavia (former)	92
Zaire	25
Zambia	16
Zimbabwe	53

* Colony

TABLE 1: BASIC INDICATORS

		Under-5 mortality rate		Infant mortality rate (under 1)		Total population (millions)	Annual no. of births (thousands)	Annual no. of under-5 deaths (thousands)	GNP per capita (US$)	Life expectancy at birth (years)	Total adult literacy rate	% of age-group enrolled in primary school (gross)	% share of household income 1980-1988	
		1960	1991	1960	1991	1991	1991	1991	1990	1991	1990	1986-1990	lowest 40%	highest 20%
Very high U5MR countries		**283**	**197**	**164**	**114**	**502**	**23629**	**4697**	**355**	**50**	**48**	**64**	. .	. .
1	Angola	345	**292**	208	170	9.6	496	153	610^x	46	42	93	. .	. .
2	Mozambique	331	**292**	190	170	14.6	672	209	80	47	33	68	. .	. .
3	Afghanistan	360	**257**	215	165	17.9	964	236	280^x	43	29	24	. .	. .
4	Sierra Leone	385	**253**	219	146	4.3	206	53	240	42	21	53	. .	. .
5	Guinea-Bissau	336	**242**	200	143	1.0	42	10	180	43	36	59	. .	. .
6	Guinea	337	**234**	203	138	5.9	303	71	480	44	24	34	. .	. .
7	Malawi	365	**228**	206	144	9.9	539	123	200	45	. .	67	. .	. .
8	Mali	400	**225**	200	108	9.5	487	111	270	45	32	23	. .	. .
9	Niger	321	**218**	191	127	8.0	414	90	310	46	28	28	. .	. .
10	Chad	325	**213**	195	125	5.7	252	54	190	47	30	57	. .	. .
11	Ethiopia	294	**212**	175	125	51.5	2543	540	120	46	. .	38	. .	. .
12	Somalia	294	**211**	175	125	9.0	457	95	150	46	24	15	. .	. .
13	Mauritania	321	**209**	191	120	2.1	97	20	500	47	34	51	. .	. .
14	Burkina Faso	363	**206**	205	120	9.3	435	89	330	48	18	36	. .	. .
15	Bhutan	324	**205**	203	133	1.6	63	13	190	48	38	26	. .	. .
16	Zambia	220	**200**	135	112	8.4	394	82	420	45	73	95	11^x	61^x
17	Liberia	310	**200**	184	131	2.7	127	25	450^x	55	40	34	. .	. .
18	Uganda	223	**190**	133	110	18.1	924	174	220	43	48	70	. .	. .
19	Rwanda	255	**189**	150	112	7.3	382	71	310	47	50	69	. .	. .
20	Nigeria	212	**188**	108	86	112.2	5181	1008	270	52	51	70	. .	. .
21	Cambodia	217	**188**	146	120	8.6	342	65	. .	50	35	. .	. .	. .
22	Senegal	299	**182**	172	82	7.5	330	61	710	49	38	58	. .	. .
23	Yemen	378	**182**	214	110	12.1	599	110	650^x	52	39	86	. .	. .
24	Burundi	260	**181**	153	108	5.7	262	47	210	48	50	69	. .	. .
25	Zaire	300	**180**	174	117	38.7	1845	333	230	52	72	78	. .	. .
26	Central African Rep.	294	**180**	174	106	3.1	138	25	390	47	38	64	. .	. .
27	Tanzania	249	**178**	147	112	26.9	1299	230	120	51	91	64	. .	. .
28	Madagascar	364	**173**	219	113	12.4	569	97	230	55	80	92	. .	. .
29	Sudan	292	**169**	170	102	26.0	1111	189	420^x	51	27	50^x	. .	. .
30	Gabon	287	**161**	171	97	1.2	50	8	3330	53	61	. .	. .	. .
31	Benin	310	**149**	184	89	4.8	235	34	360	46	23	66	. .	. .
32	Lao, Peo. Dem.	233	**148**	155	101	4.3	196	28	200	50	. .	110	. .	. .
33	Nepal	298	**147**	186	102	20.1	776	114	170	53	26	85	13^x	59^x
34	Togo	305	**144**	182	88	3.7	164	23	410	54	43	103	. .	. .
35	Iraq	171	**143**	117	111	18.7	735	106	2340^x	66	60	96	. .	. .
High U5MR countries		**231**	**116**	**143**	**80**	**1672**	**53579**	**6176**	**525**	**59**	**54**	**93**	**18**	**44**
36	Lesotho	210	**137**	149	82	1.8	63	9	470	60	. .	107	. .	. .
37	Haiti	270	**137**	182	89	6.6	236	32	370	56	53	84	6	48
38	Ghana	224	**137**	132	84	15.5	659	90	390	55	60	75	17	45
39	Pakistan	221	**134**	148	94	121.5	5044	671	380	58	35	38	19	46
40	Bangladesh	247	**133**	151	101	116.6	4514	583	200	52	35	70	24	37
41	Côte d'Ivoire	300	**127**	165	93	12.5	624	77	730	52	54	70	13	53
42	India	236	**126**	144	84	863.2	25654	3221	350	60	48	97	20	41
43	Cameroon	270	**126**	163	66	11.9	489	60	940	55	54	101	. .	. .
44	Bolivia	282	**126**	167	89	7.4	258	32	620	60	78	82	12	58
45	Namibia	248	**120**	146	73	1.5	64	8	1030^x	58	. .	. .	. .	. .
46	Myanmar	237	**117**	158	85	42.8	1411	164	220^x	57	81	103	. .	. .
47	Congo	220	**110**	143	83	2.3	103	11	1010	52	57	. .	. .	. .
48	Libyan Arab Jamahiriya	269	**108**	160	72	4.7	201	21	5310^x	62	64	. .	. .	. .
49	Peru	240	**97**	142	68	22.0	652	63	1160	64	85	123	13	52
50	Guatemala	220	**92**	125	52	9.5	373	34	900	64	55	76	14^x	55^x
51	Morocco	265	**91**	163	72	25.7	853	77	950	63	50	68	23	39
52	Turkey	216	**89**	160	72	57.2	1633	146	1630	67	81	113	11	55
53	Zimbabwe	181	**88**	109	61	10.3	422	36	640	56	67	128	. .	. .
54	Indonesia	215	**86**	128	61	187.7	5104	437	570	62	77	118	21	41
55	Botswana	169	**85**	116	62	1.3	50	4	2040	60	74	115	9	59
56	Egypt	260	**85**	168	62	53.6	1735	146	600	61	48	97	21	41
57	Ecuador	184	**82**	124	59	10.8	329	27	960	66	86	118	. .	. .
58	Mongolia	185	**82**	128	62	2.3	78	6	780^x	63	. .	102	. .	. .
59	Nicaragua	209	**81**	140	58	3.8	160	13	830^x	65	. .	95	12	58
60	Papua New Guinea	248	**79**	165	55	4.0	134	10	860	55	52	73	. .	. .
61	Dominican Rep.	200	**76**	125	59	7.3	213	16	820	67	83	96	. .	. .
62	Kenya	202	**75**	120	52	24.4	1085	79	370	59	69	94	9^x	60^x
63	Honduras	230	**73**	160	62	5.3	201	15	590	65	73	109	12	59
64	South Africa	126	**72**	89	54	38.9	1237	88	2530	62	. .	. .	. .	. .
Middle U5MR countries		**174**	**36**	**114**	**29**	**2226**	**50370**	**1804**	**1465**	**69**	**76**	**120**	**15**	. .
65	Brazil	179	**67**	117	55	151.5	3668	247	2680	66	81	. .	8	63
66	El Salvador	210	**67**	130	50	5.3	180	12	1100	65	73	78	8	66
67	Iran, Islamic Rep. of	233	**62**	145	47	60.0	2437	149	2450	67	54	108	. .	. .
68	Algeria	243	**61**	148	50	25.7	886	53	2060	66	57	96	. .	. .
69	Paraguay	103	**59**	66	48	4.4	148	9	1110	67	90	106	. .	. .
70	Tunisia	254	**58**	159	45	8.2	228	13	1420	67	65	115	. .	. .

		Under-5 mortality rate		Infant mortality rate (under 1)		Total population (millions)	Annual no. of births (thousands)	Annual no. of under-5 deaths (thousands)	GNP per capita (US$)	Life expectancy at birth (years)	Total adult literacy rate	% of age-group enrolled in primary school Total	% share of household income 1980-1988	
		1960	1991	1960	1991	1991	1991	1991	1990	1991	1990	1986-1990	lowest 40%	highest 20%
71	Viet Nam	219	**52**	147	39	68.1	2040	105	240^{x}	63	88	102	. .	. .
72	Syria	217	**47**	135	37	12.8	552	25	990	66	65	108	. .	. .
73	Jordan	180	**46**	135	39	4.2	165	7	1240	67	80	99	. .	. .
74	Lebanon	91	**46**	68	36	2.8	77	4	2150^{x}	68	80	100	. .	. .
75	Philippines	128	**46**	81	34	63.8	1975	90	730	65	90	111	14	52
76	Venezuela	114	**43**	81	34	19.8	528	22	2560	70	88	105	14	51
77	Saudi Arabia	292	**43**	170	33	15.4	560	24	7050	69	62	76	. .	. .
78	Oman	378	**42**	214	32	1.6	65	3	5220^{x}	69	. .	102	. .	. .
79	Mexico	138	**37**	97	30	86.3	2462	91	2490	70	87	117	13	. .
80	Romania	82	**34**	69	27	23.3	367	12	1640	70	. .	96	. .	. .
81	Korea, Dem. Peo. Rep.	120	**34**	85	25	22.2	533	18	970^{x}	71	. .	107	. .	. .
82	Thailand	146	**33**	101	28	55.4	1169	38	1420	69	93	89	15^{x}	50^{x}
83	USSR (former)	53	**31**	38	23	282.8	4847	156	4550^{x}	70	. .	105	. .	. .
84	Albania	151	**31**	112	26	3.3	76	2	790^{x}	73	. .	99	. .	. .
85	Panama	105	**30**	69	21	2.5	63	2	1830	73	88	107	. .	. .
86	United Arab Emirates	239	**29**	145	24	1.6	35	1	19860	71	48	111	. .	. .
87	Mauritius	104	**28**	70	22	1.1	20	1	2250	70	. .	103	12	46
88	China	205	**27**	133	22	1170.4	24592	661	370	70	73	135	22	38
89	Uruguay	57	**24**	51	21	3.1	54	1	2560	72	96	107	18	44
90	Argentina	70	**24**	59	22	32.7	673	16	2370	71	95	111	14	51
91	Trinidad and Tobago	69	**23**	56	20	1.3	30	1	3470	71	. .	97	13^{x}	50^{x}
92	Yugoslavia (former)	113	**22**	92	19	23.9	343	8	3060	72	93	95	17	43
93	Bulgaria	70	**21**	49	17	9.0	113	2	2250	72	. .	97	. .	. .
94	Chile	142	**21**	114	17	13.4	307	6	1940	72	93	98	13	54
95	Sri Lanka	130	**21**	90	16	17.4	371	8	470	71	88	108	13	56
96	Colombia	130	**21**	88	18	32.9	806	17	1240	69	87	107	13	53
Low U5MR countries		**48**	**11**	**38**	**9**	**959**	**13428**	**144**	**17580**	**76**	**. .**	**103**	**18**	**41**
97	Malaysia	105	**20**	73	15	18.3	541	11	2340	70	78	97	14	51
98	Jamaica	89	**19**	63	15	2.4	55	1	1510	73	98	105	15	49
99	Costa Rica	122	**18**	85	14	3.1	84	2	1910	76	93	100	12	55
100	Hungary	57	**17**	51	16	10.5	128	2	2780	70	. .	97	26	32
101	Poland	70	**17**	62	15	38.3	566	10	1690	71	. .	99	24	35
102	Kuwait	128	**17**	89	14	2.0	53	1	16150^{x}	75	73	100	. .	. .
103	Cuba	91	**14**	65	11	10.7	187	3	1170^{x}	76	94	103	. .	. .
104	Czechoslovakia	33	**13**	26	12	15.7	220	3	3140	72	. .	93	. .	. .
105	Israel	39	**12**	32	10	4.9	108	1	10920	76	. .	94	18^{x}	40^{x}
106	Portugal	112	**12**	81	10	9.9	117	1	4900	74	85	127	. .	. .
107	USA	30	**11**	26	9	252.6	4024	43	21790	76	. .	101	16	42
108	Greece	64	**11**	53	10	10.1	106	1	5990	77	93	102	. .	. .
109	Ireland	36	**10**	31	8	3.5	52	1	9550	75	. .	101	. .	. .
110	Singapore	50	**10**	36	8	2.7	44	0	12310	74	. .	110	15	49
111	Belgium	35	**10**	31	8	10.0	121	1	15540	76	. .	101	22^{x}	36^{x}
112	Australia	24	**10**	20	8	17.3	261	3	17000	77	. .	106	16	42
113	Italy	50	**10**	44	8	57.7	575	6	16830	77	97	96	19	41
114	New Zealand	26	**10**	22	8	3.4	59	1	12680	75	. .	106	16	45
115	Korea, Rep. of	126	**10**	88	9	43.7	714	7	5400	70	96	109	20	42
116	Canada	33	**9**	28	7	27.0	388	3	20470	77	. .	105	18	40
117	Germany	40	**9**	34	8	79.8	901	8	22320^{x}	76	. .	103	20^{x}	39^{x}
118	Denmark	25	**9**	22	8	5.2	62	1	22080	75	. .	98	17	39
119	Switzerland	27	**9**	22	7	6.8	84	1	32680	78	. .	. .	17	45
120	France	34	**9**	29	7	56.9	772	7	19490	77	. .	113	18^{x}	41^{x}
121	United Kingdom	27	**9**	23	7	57.5	792	7	16100	76	. .	106	17^{x}	40^{x}
122	Austria	43	**9**	37	8	7.7	90	1	19060	76	. .	104	. .	. .
123	Spain	57	**9**	46	8	39.0	423	4	11020	77	95	111	19	40
124	Hong Kong	64	**8**	43	7	5.8	73	1	11540	77	. .	105	16	47
125	Netherlands	22	**8**	18	7	15.1	202	2	17320	77	. .	116	20	38
126	Norway	23	**8**	19	7	4.3	61	1	23120	77	. .	98	19	38
127	Finland	28	**7**	22	6	5.0	64	0	26040	75	. .	99	18	38
128	Japan	40	**6**	31	5	124.0	1384	9	25430	79	. .	102	22^{x}	38^{x}
129	Sweden	20	**5**	16	4	8.6	117	1	23660	78	. .	104	21	37

Regional summaries													
Least developed countries	286	180	172	115	519	22973	4128	240	50	47	66	. .	. .
Developing countries	217	101	136	67	4147	123583	12523	805	61	65	100	. .	. .
Developed countries	45	17	36	13	1213	17423	298	14710	74	. .	103	18	40
Sub-Saharan Africa	261	180	151	103	515	23659	4299	490	51	54	68	. .	. .
Middle East & North Africa	246	90	157	66	332	11925	1075	1975	63	58	95	. .	. .
South Asia	238	131	147	89	1158	37386	4846	335	58	46	86	20	42
East Asia & Pacific	198	42	128	32	1700	38946	1641	650	68	76	125	20	42
Latin America & Caribbean	161	57	108	44	442	11667	662	2105	67	85	108	11	59

Countries listed in descending order of U5MR (shown in bold type). Figures in coloured bands are totals or ***weighted*** *averages.*

TABLE 2: NUTRITION

		% of infants with low birth weight 1990	% of children (1986-91) who are:			% of children (1980-91) suffering from:				Average index of food production per capita (1979-81=100) 1991	Daily per capita calorie supply as a % of requirements 1988-90	% of household income (1980-85) spent on:	
			exclusively breastfed (0-3 months)	breastfed with complementary food (6-9 months)	still breastfeeding (12-15 months)	underweight (0-4 years)		wasting (12-23 months)	stunting (24-59 months)				
						moderate & severe	severe	moderate & severe	moderate & severe			all food	cereals
Very high U5MR countries		**16**	**. .**	**. .**	**82**	**34**	**. .**	**15**	**. .**	**96**	**91**	**. .**	**. .**
1	Angola	19	. .	. .	. .	. .	. .	. .	. .	80	80	. .	. .
2	Mozambique	20	. .	. .	. .	. .	. .	. .	. .	68	77	. .	. .
3	Afghanistan	20	. .	. .	61^{x}	38	7	. .	. .	73	72	. .	. .
4	Sierra Leone	17	. .	. .	92^{x}	23^{x}	2^{x}	14^{x}	. .	84	83	56	22
5	Guinea-Bissau	20	. .	. .	98^{x}	23^{x}	. .	. .	. .	104	97	. .	. .
6	Guinea	21	. .	. .	85^{x}	. .	. .	. .	. .	88	97	. .	. .
7	Malawi	20	. .	. .	96^{x}	24^{x}	. .	8	61	77	88	55	28
8	Mali	17	8	45	90	31^{x}	9^{x}	16	34^{x}	97	96	57	22
9	Niger	15	. .	. .	15^{x}	49	9	23^{x}	38^{x}	73	95	. .	. .
10	Chad	. .	. .	. .	. .	. .	. .	. .	. .	97	73	. .	. .
11	Ethiopia	16	. .	. .	95^{x}	38^{x}	. .	19^{x}	43^{x}	87	73	50	24
12	Somalia	16	. .	. .	54^{x}	. .	. .	. .	. .	81	81	. .	. .
13	Mauritania	11	12	39	89	48	23	18	65	75	106	. .	. .
14	Burkina Faso	21^{x}	. .	. .	97^{x}	. .	. .	. .	. .	118	94	. .	. .
15	Bhutan	. .	. .	. .	90^{x}	38^{x}	. .	4^{x}	56^{x}	94	128	. .	. .
16	Zambia	13	. .	. .	93^{x}	25^{x}	5^{x}	10^{x}	59^{x}	98	87	37	8
17	Liberia	. .	15	56	67	. .	. .	. .	. .	63	98	. .	. .
18	Uganda	. .	70	67	86	23	5	4	25^{x}	97	93	. .	. .
19	Rwanda	17	. .	. .	74^{x}	33^{x}	4^{x}	1^{x}	34^{x}	86	82	30	11
20	Nigeria	16	2	52	86	36	12	16	54	124	93	52	18
21	Cambodia	. .	. .	. .	72^{x}	20	3	. .	. .	140	96	. .	. .
22	Senegal	11	7	68	93	22^{x}	6^{x}	8	28^{x}	96	98	50	15
23	Yemen	19	15	. .	. .	53^{x}	. .	15^{x}	. .	79	. .	. .	. .
24	Burundi	. .	89	66	96	38	10	10	60	88	84	. .	. .
25	Zaire	15	. .	. .	86^{x}	. .	. .	. .	. .	94	96	55	15
26	Central African Rep.	15	. .	. .	. .	. .	. .	. .	. .	93	82	. .	. .
27	Tanzania	14	. .	. .	70^{x}	48	6	. .	. .	81	95	64	32
28	Madagascar	10	. .	. .	85^{x}	33^{x}	8^{x}	17	56^{x}	83	95	59	26
29	Sudan	15	14	45	80	20	. .	13^{x}	32^{x}	76	87	60	. .
30	Gabon	. .	. .	. .	. .	. .	. .	. .	. .	85	104	. .	. .
31	Benin	. .	. .	. .	76^{x}	. .	. .	. .	. .	114	104	37	12
32	Lao, Peo. Dem.	18	. .	. .	. .	37	. .	20	44	110	111	. .	. .
33	Nepal	. .	. .	. .	82^{x}	. .	. .	. .	. .	124	100	57	38
34	Togo	20	10	86	95	24	6	10	37^{x}	87	99	. .	. .
35	Iraq	15	. .	. .	58	12	2	. .	. .	65	128	. .	. .
High U5MR countries		**27**	**. .**	**. .**	**77**	**50**	**21**	**20**	**59**	**110**	**105**	**47**	**16**
36	Lesotho	11	. .	. .	76^{x}	16	2	7	23	80	93	. .	. .
37	Haiti	15	. .	. .	29^{x}	37^{x}	3^{x}	17^{x}	51^{x}	83	89	. .	. .
38	Ghana	17	2	57	94	27	6	15	39	105	93	66	. .
39	Pakistan	25	25	29	78	40	14	11	60	102	99	54	17
40	Bangladesh	50	. .	. .	82^{x}	66^{x}	27^{x}	16^{x}	65	96	88	59	36
41	Côte d'Ivoire	14^{x}	. .	. .	78^{x}	12	2	17	20	93	111	40	14
42	India	33	. .	. .	. .	63^{x}	27^{x}	27	65^{x}	116	101	52	18
43	Cameroon	13	7	. .	. .	17^{x}	. .	2^{x}	43^{x}	79	95	24	8
44	Bolivia	12	59	57	73	13	3	2	51^{x}	125	84	33	. .
45	Namibia	12	. .	. .	73^{x}	29^{x}	6^{x}	9^{x}	30^{x}	92	. .	. .	. .
46	Myanmar	16	. .	. .	94^{x}	32	9	. .	. .	88	114	. .	. .
47	Congo	16	. .	. .	90^{x}	24	. .	13	33	97	103	42	19
48	Libyan Arab Jamahiriya	. .	. .	. .	. .	. .	. .	. .	. .	74	140	. .	. .
49	Peru	11	32	49	57	13^{x}	2^{x}	3	43	93	87	35	8
50	Guatemala	14	. .	. .	82	34^{x}	8^{x}	3	68^{x}	95	103	36	10
51	Morocco	9	48	48	62	16^{x}	4^{x}	6	34^{x}	134	125	40	12
52	Turkey	8	. .	. .	63^{x}	. .	. .	. .	. .	99	127	40	8
53	Zimbabwe	14	11	94	90	12	2	2	31	76	94	40	9
54	Indonesia	14	39	82	82	40	. .	. .	. .	125	121	61	18
55	Botswana	8	41	82	77	15	. .	. .	. .	63	97	35	13
56	Egypt	10	38	52	77	10	3	4	32	106	132	50	10
57	Ecuador	11	31	31	51	17	0	4	39	99	105	30	. .
58	Mongolia	10	. .	. .	. .	. .	. .	. .	. .	76	97	. .	. .
59	Nicaragua	15	. .	. .	. .	11	1	0	22	62	99	. .	. .
60	Papua New Guinea	23	. .	. .	. .	35	. .	. .	. .	98	114	. .	. .
61	Dominican Rep.	16	14	24	23	13^{x}	2^{x}	3	26^{x}	81	102	46	13
62	Kenya	16	24	87	83	14^{x}	3^{x}	5^{x}	32^{x}	103	89	39	16
63	Honduras	9	. .	. .	24^{x}	21	4	2^{x}	34^{x}	81	98	39	. .
64	South Africa	. .	. .	. .	. .	. .	. .	. .	. .	81	128	26	. .
Middle U5MR countries		**10**	**. .**	**. .**	**41**	**21**	**. .**	**9**	**36**	**122**	**116**	**42**	**. .**
65	Brazil	11	4	28	25	7	3	2^{x}	15^{x}	115	114	35	9
66	El Salvador	11	. .	. .	55^{x}	. .	. .	3	36	103	102	33	12
67	Iran, Islamic Rep. of	9	. .	. .	51^{x}	43^{x}	. .	23^{x}	55^{x}	114	125	37	10
68	Algeria	9	. .	. .	. .	10^{x}	. .	4^{x}	13^{x}	104	123	. .	. .
69	Paraguay	8	7	61	40	4	1	0	17	116	116	30	6
70	Tunisia	8	21	53	57	10^{x}	2^{x}	4	23^{x}	102	131	37	7

		% of infants with low birth weight 1990	% of children (1986-91) who are:			% of children (1980-91) suffering from:				Average index of food production per capita (1979-81=100) 1991	Daily per capita calorie supply as a % of requirements 1988-90	% of household income (1980-85) spent on:	
			exclusively breastfed	breastfed with complementary food	still breastfeeding	underweight (0-4 years)		wasting (12-23 months)	stunting (24-59 months)				
			(0-3 months)	(6-9 months)	(12-15 months)	moderate & severe	severe	moderate & severe	moderate & severe			all food	cereals
71	Viet Nam	17	. .	. .	49^x	42	14	12^x	49^x	131	103	. .	. .
72	Syria	11	. .	. .	41^x	. .	. .	. .	. .	73	126	. .	. .
73	Jordan	7	32	. .	61^x	6	1	3	21	82	110	35	. .
74	Lebanon	10	. .	. .	15^x	. .	. .	. .	. .	132	127	. .	. .
75	Philippines	15	. .	. .	53^x	34	5	14	45	82	104	51	20
76	Venezuela	9	. .	. .	30^x	6^x	. .	4	7^x	99	99	38	. .
77	Saudi Arabia	7	. .	. .	. .	. .	. .	. .	. .	223	121	. .	. .
78	Oman	10	. .	. .	76	. .	. .	. .	. .	. .	. .	. .	. .
79	Mexico	12	38	36	32	14	. .	6^x	22^x	97	131	35	. .
80	Romania	7	. .	. .	. .	. .	. .	. .	. .	70	116	. .	. .
81	Korea, Dem. Peo. Rep.	. .	. .	. .	. .	. .	. .	. .	. .	109	121	. .	. .
82	Thailand	13	4	69	58	26^x	4^x	10	28^x	109	103	30	7
83	USSR (former)	6	. .	. .	. .	. .	. .	. .	. .	96	132	. .	. .
84	Albania	7	. .	. .	. .	. .	. .	. .	. .	62	107	. .	. .
85	Panama	10	. .	. .	55^x	16	. .	7	24	81	98	38	7
86	United Arab Emirates	6	. .	. .	26	. .	. .	. .	. .	. .	. .	. .	. .
87	Mauritius	9	. .	. .	40^x	24	. .	16^x	22^x	94	128	24	7
88	China	9	. .	. .	. .	21^x	3^x	8^x	41^x	138	112	61	. .
89	Uruguay	8	. .	. .	. .	7^x	2^x	. .	16^x	108	101	31	7
90	Argentina	8	. .	. .	14^x	. .	4	. .	. .	95	131	35	4
91	Trinidad and Tobago	10	10	39	30	7^x	0^x	5	4^x	87	114	. .	. .
92	Yugoslavia (former)	. .	. .	. .	. .	. .	. .	. .	. .	87	140	27	. .
93	Bulgaria	6	. .	. .	. .	. .	. .	. .	. .	88	148	. .	. .
94	Chile	7	. .	. .	20^x	3^x	0^x	1	10^x	118	102	29	7
95	Sri Lanka	25	14	47	71	29	2	21	39	89	101	43	18
96	Colombia	10	17	48	39	10	2	5	18	104	106	29	. .
Low U5MR countries		**7**	. .	. .	. .	. .	. .	. .	. .	**102**	**133**	**15**	**3**
97	Malaysia	10	. .	. .	19^x	. .	4	6	. .	146	120	30	. .
98	Jamaica	11	. .	. .	43^x	7	1	6	7	96	114	39	. .
99	Costa Rica	6	. .	. .	24^x	6	. .	3	8	90	121	33	8
100	Hungary	9	. .	. .	. .	. .	. .	. .	. .	114	137	25	. .
101	Poland	. .	. .	. .	. .	. .	. .	. .	. .	103	131	29	. .
102	Kuwait	7	. .	. .	12^x	6	. .	2	14	. .	. .	. .	. .
103	Cuba	8	. .	. .	. .	. .	. .	1^x	. .	96	135	. .	. .
104	Czechoslovakia	6	. .	. .	. .	. .	. .	. .	. .	118	145	. .	. .
105	Israel	7	. .	. .	. .	. .	. .	. .	. .	91	125	22	. .
106	Portugal	5	. .	. .	7	. .	. .	. .	. .	117	136	34	. .
107	USA	7	. .	. .	. .	. .	. .	. .	. .	94	138	13	2
108	Greece	6	. .	. .	. .	. .	. .	. .	. .	104	151	30	. .
109	Ireland	4	. .	. .	. .	. .	. .	. .	. .	118	157	22	4
110	Singapore	7	. .	. .	. .	14^x	. .	. .	. .	70	136	19	. .
111	Belgium	6	. .	. .	. .	. .	. .	. .	. .	110	149	15	2
112	Australia	6	. .	. .	10	. .	. .	. .	. .	92	124	13	2
113	Italy	5	. .	. .	. .	. .	. .	. .	. .	99	139	19	2
114	New Zealand	6	. .	. .	. .	. .	. .	. .	. .	102	131	12	2
115	Korea, Rep. of	9	. .	. .	27^x	. .	. .	. .	. .	100	120	35	14
116	Canada	6	. .	. .	. .	. .	. .	. .	. .	117	122	11	2
117	Germany	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .
118	Denmark	6	. .	. .	. .	. .	. .	. .	. .	132	135	13	2
119	Switzerland	5	. .	. .	. .	. .	. .	. .	. .	100	130	17	. .
120	France	5	. .	. .	. .	. .	. .	. .	. .	106	143	16	2
121	United Kingdom	7	. .	. .	. .	. .	. .	. .	. .	108	130	12	2
122	Austria	6	. .	. .	. .	. .	. .	. .	. .	103	133	16	2
123	Spain	4	. .	. .	. .	. .	. .	. .	. .	111	141	24	3
124	Hong Kong	8	. .	. .	. .	. .	. .	. .	. .	111	125	12	1
125	Netherlands	. .	. .	. .	. .	. .	. .	. .	. .	103	114	13	2
126	Norway	4	. .	. .	. .	. .	. .	. .	. .	108	120	15	2
127	Finland	4	. .	. .	. .	. .	. .	. .	. .	98	113	16	3
128	Japan	6	. .	. .	. .	. .	. .	. .	. .	99	125	16	4
129	Sweden	5	. .	. .	. .	. .	. .	. .	. .	96	111	13	2

Regional summaries												
Least developed countries	24	. .	. .	82	42	14	15	50	91	90	. .	. .
Developing countries	19	. .	. .	68	36	12	14	47	116	107	43	. .
Developed countries	6	. .	. .	. .	. .	. .	. .	. .	99	133	15	2
Sub-Saharan Africa	16	. .	. .	84	31	8	13	44	96	93	37	16
Middle East & North Africa	10	. .	. .	62	24	. .	. .	. .	106	123	. .	. .
South Asia	34	. .	. .	78	59	25	23	64	112	99	53	19
East Asia & Pacific	11	. .	. .	66	26	. .	. .	. .	130	112	49	. .
Latin America & Caribbean	11	. .	. .	33	11	3	4	23	104	114	35	8

*Countries listed in descending order of U5MR. Figures in coloured bands are totals or **weighted** averages.*

TABLE 3: HEALTH

		% of population with access to safe water 1988-90			% of population with access to adequate sanitation 1988-90			% of population with access to health services 1985-88			% fully immunized 1990-91					
											1 year-old children					
		total	urban	rural	total	urban	rural	total	urban	rural	TB	DPT	polio	measles	pregnant women tetanus	ORT use rate 1987-91
Very high U5MR countries		**43**	**62**	**35**	**43**	**66**	**33**	**52**	**. .**	**. .**	**62**	**47**	**46**	**46**	**28**	**39**
1	Angola	35	75	19	21	25	20	30^{x}	. .	. .	54	27	26	40	36	48
2	Mozambique	24	44	17	21	53	12	39	100	30	63	42	42	50	30	30
3	Afghanistan	21	39	17	. .	5	. .	29	80	17	39	30	30	29	9	26
4	Sierra Leone	36	33	37	63	92	49	. .	. .	. .	71	56	57	54	77	60
5	Guinea-Bissau	27	17	30	21	29	18	. .	. .	. .	94	63	63	52	35	5
6	Guinea	51	78	42	6	22	1	47	100	40	47	35	35	33	25	65
7	Malawi	56^{x}	97^{x}	50^{x}	84	100	81	80	. .	. .	96	81	78	78	76	14
8	Mali	41	53	38	19	90	3	15	. .	. .	68	34	34	39	9	. .
9	Niger	61	100	52	9	36	3	41	99	30	26	17	17	23	44	54
10	Chad	57	25	70	. .	. .	. .	30	. .	. .	27	12	12	21	4	15
11	Ethiopia	19	70	11	19	97	7	46	. .	. .	29	21	21	17	6	38
12	Somalia	37	50	29	18	44	5	27^{x}	50^{x}	15^{x}	31	18	18	30	5	78
13	Mauritania	66	100	100	39	69	13	40	. .	. .	60	26	26	29	40	. .
14	Burkina Faso	69	44	72	. .	49	. .	49^{x}	51^{x}	48^{x}	60	38	38	36	26	. .
15	Bhutan	32	60	30	9	50	7	65	. .	. .	81	79	77	82	43	65
16	Zambia	60	76	43	56	76	34	75^{x}	100^{x}	50^{x}	97	79	78	76	68	89
17	Liberia	55	93	22	. .	. .	2	39	50	30	62^{x}	28^{x}	28^{x}	55^{x}	20^{x}	9
18	Uganda	21	43	18	30	32	30	61	90	57	100	76	76	73	21	30
19	Rwanda	50^{x}	79^{x}	48^{x}	57	77	55	27^{x}	60^{x}	25^{x}	94	85	85	81	88	24
20	Nigeria	53	50	54	58	63	55	66	85	62	57	44	44	46	26	35
21	Cambodia	18	40	15	13	53	8	53	80	50	54	40	40	34	22	6
22	Senegal	47	84	25	53	86	36	40	. .	. .	69	51	51	46	33	27
23	Yemen	38	56	30	37	51	64	38	. .	. .	71	53	53	45	8	7
24	Burundi	38	100	34	10	80	5	61	. .	. .	88	83	89	75	56	49
25	Zaire	33	59	17	. .	. .	. .	26	40	17	65	32	31	31	29	45
26	Central African Rep.	26	32	21	. .	. .	48	45	. .	. .	42	25	26	25	87	24
27	Tanzania	56	75	46	68	93	58	76^{x}	99^{x}	72^{x}	89	79	74	75	40	83
28	Madagascar	22	62	10	. .	9	. .	56	. .	. .	67	50	49	40	17	11
29	Sudan	46	55	43	71	89	66	51	90	40	66	63	63	59	16	37
30	Gabon	68	90	50	. .	. .	. .	90^{x}	. .	. .	96	78	78	76	86	10
31	Benin	54	66	46	35	42	31	18	. .	. .	81	68	68	60	83	45
32	Lao, Peo. Dem.	35	50	32	13	49	5	67	. .	. .	34	22	22	20	13	30
33	Nepal	37	66	34	2	17	1	. .	. .	. .	81	74	74	63	17	14
34	Togo	59	76	53	22	56	10	61	. .	. .	79	61	61	51	81	33
35	Iraq	92	100	72	75	100	11	93	97	78	79	63	64	68	45	70
High U5MR countries		**75**	**83**	**71**	**23**	**56**	**10**	**61**	**. .**	**. .**	**86**	**80**	**80**	**76**	**65**	**26**
36	Lesotho	48	59	45	15	22	14	80	. .	. .	76	75	74	76	. .	68
37	Haiti	36	59	27	21	42	13	50	. .	. .	72	41	40	31	23	20
38	Ghana	57	90	41	52	92	33	60	92	45	55	39	39	39	9	21
39	Pakistan	56	80	45	24	55	10	55	99	35	91	81	81	77	42	34
40	Bangladesh	81	76	81	16	57	8	45	. .	. .	86	60	60	53	78	26
41	Côte d'ivoire	76	70	80	60	73	51	30^{x}	61^{x}	11^{x}	47	37	37	47	35	16
42	India	86	87	85	16	53	2	. .	. .	. .	92	89	89	86	80	14
43	Cameroon	42	46	39	46	100	1	41	44	39	48	34	34	35	35	84
44	Bolivia	53	77	27	27	40	13	63	90	36	67	58	67	73	52	63
45	Namibia	. .	. .	. .	. .	. .	. .	. .	. .	. .	68	87	82	71	52	. .
46	Myanmar	31	38	30	36	39	35	33	100	11	65	62	62	63	61	19
47	Congo	38	92	2	. .	. .	. .	83	97	70	88	74	74	64	60	26
48	Libyan Arab Jamahiriya	94	100	80	91	100	72	. .	. .	. .	91	62	62	59	18	60
49	Peru	61	78	10	59	76	20	75	. .	. .	78	71	74	59	12	. .
50	Guatemala	62	91	43	59	72	52	34	47	25	43	63	69	49	18	24
51	Morocco	61	100	25	. .	. .	16	70	100	50	92	81	81	80	64	13
52	Turkey	78^{x}	95^{x}	63^{x}	. .	. .	. .	. .	. .	. .	52	72	72	66	20	. .
53	Zimbabwe	66	31	80	. .	. .	. .	71	100	62	87	83	81	83	60	77
54	Indonesia	58	72	51	39	51	33	80	. .	. .	87	83	82	78	52	45
55	Botswana	54^{x}	84^{x}	46^{x}	42	98	20	89^{x}	100^{x}	85^{x}	92	86	82	78	62	64
56	Egypt	73	92	56	. .	. .	10	. .	. .	. .	93	93	87	90	71	58
57	Ecuador	58	75	44	67	98	38	75	92	40	83	59	62	54	5	70
58	Mongolia	65	78	50	. .	. .	. .	. .	. .	. .	92	84	85	86	. .	59
59	Nicaragua	54	78	18	27	30	16	83	100	60	75	71	83	54	25	40
60	Papua New Guinea	34	93	23	45	99	35	96	. .	. .	68	53	54	52	3	46
61	Dominican Rep.	63	86	28	28	41	10	80	. .	. .	45	47	64	69	24	31
62	Kenya	30^{x}	61^{x}	21^{x}	34	89	19	. .	. .	. .	80	74	71	59	37	69
63	Honduras	65	86	48	58	79	42	66	80	56	99	94	93	86	16	70
64	South Africa	. .	. .	. .	. .	. .	. .	. .	. .	. .	85	67	69	63	. .	. .
Middle U5MR countries		**76**	**89**	**67**	**67**	**83**	**46**	**87**	**. .**	**. .**	**93**	**87**	**92**	**89**	**54**	**55**
65	Brazil	97	100	86	64	86	1	. .	. .	. .	80	75	96	83	62	62
66	El Salvador	48	84	19	58	86	36	56	80	40	66	60	60	53	19	45
67	Iran, Islamic Rep. of	89	98	76	63	86	32	80	95	65	91	88	88	84	77	71
68	Algeria	68^{x}	85^{x}	55^{x}	57	80	40	88	100	80	99	89	89	83	27	26
69	Paraguay	34	65	7	86	89	83	61	. .	. .	93	79	79	74	54	42
70	Tunisia	92	97	86	96	98	94	90^{x}	100^{x}	80^{x}	80	91	91	82	40	63

		% of population with access to safe water 1988-90			% of population with access to adequate sanitation 1988-90			% of population with access to health services 1985-88			% fully immunized 1990-91 1 year-old children				% fully immunized 1990-91 pregnant women	ORT use rate 1987-91
		total	urban	rural	total	urban	rural	total	urban	rural	TB	DPT	polio	measles	tetanus	
71	Viet Nam	42	50	40	62	70	60	80	100	75	91	88	88	88	14	53
72	Syria	70	90	50	85	85	84	75[x]	92[x]	60[x]	98	92	92	87	84	89
73	Jordan	99	100	98	61	92	. .	97	98	95	. .	91	91	83	47	77
74	Lebanon	92	95	85	. .	. .	. .	. .	. .	. .	4	85	85	51	. .	10
75	Philippines	81	93	72	67	83	63	. .	. .	. .	96	89	90	88	52	25
76	Venezuela	90[x]	93[x]	65[x]	51	57	5	. .	. .	. .	83	54	63	61	. .	80
77	Saudi Arabia	94	100	74	. .	100	. .	97	100	88	97	96	96	90	62	45
78	Oman	55	100	49	48	75	45	91	100	90	92	94	94	96	97	19
79	Mexico	71	79	49	58	77	13	78	80	60	87	64	95	78	42	66
80	Romania	. .	. .	. .	. .	. .	. .	. .	. .	. .	90	96	92	89	. .	. .
81	Korea, Dem. Peo. Rep.	. .	. .	. .	. .	. .	. .	. .	. .	. .	99	98	99	99	99	72
82	Thailand	93	97	92	91	79	95	90	90	90	99	90	91	79	76	43
83	USSR (former)	. .	. .	. .	. .	. .	. .	. .	. .	. .	90	67	74	85	. .	. .
84	Albania	. .	. .	. .	. .	. .	. .	. .	. .	. .	94	94	96	87	. .	. .
85	Panama	84	100	66	81	99	61	80[x]	95[x]	64[x]	87	82	82	80	27	55
86	United Arab Emirates	95	. .	. .	77	93	22	99	. .	. .	96	84	84	81	. .	81
87	Mauritius	95	100	92	92	100	86	100	100	100	87	91	91	88	77	7
88	China	74	87	68	. .	. .	. .	90	100	88	96	95	96	95	. .	54
89	Uruguay	73	85	5	. .	. .	. .	82	. .	. .	99	88	88	82	13	96
90	Argentina	65	73	17	69	75	35	71	80	21	99	84	88	99	. .	70
91	Trinidad and Tobago	96	100	87	98	100	95	99	. .	. .	. .	73	74	81	. .	70
92	Yugoslavia (former)	. .	. .	. .	. .	. .	. .	. .	. .	. .	89	. .	86	88	. .	. .
93	Bulgaria	. .	. .	. .	. .	. .	. .	. .	. .	. .	99	99	99	98	. .	. .
94	Chile	89	100	21	85	100	4	97	. .	. .	90	91	91	93	. .	1
95	Sri Lanka	60	80	55	59	68	56	93[x]	. .	. .	85	83	83	76	50	76
96	Colombia	88	88	87	70	96	13	60	. .	. .	93	87	94	83	40	40
Low U5MR countries		. .	. .	. .	. .	. .	. .	. .	. .	. .	**77**	**89**	**88**	**78**	. .	. .
97	Malaysia	79	96	66	76	100	60	. .	. .	. .	99	90	90	79	83	47
98	Jamaica	100	100	100	85	96	74	90	. .	. .	94	83	86	68	50	10
99	Costa Rica	92	100	84	94	99	89	80[x]	100[x]	63[x]	92	95	95	90	68	78
100	Hungary	. .	. .	. .	. .	. .	. .	. .	. .	. .	99	99	99	99	. .	. .
101	Poland	. .	. .	. .	. .	. .	. .	. .	. .	. .	95	98	99	96	. .	. .
102	Kuwait	. .	100	. .	. .	100	. .	100	. .	. .	3	92	92	93	22	10
103	Cuba	. .	. .	. .	. .	. .	. .	. .	. .	. .	98	99	97	99	88	80
104	Czechoslovakia	. .	. .	. .	. .	. .	. .	. .	. .	. .	98	99	99	98	. .	. .
105	Israel	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	88	88	88	. .	. .
106	Portugal	. .	. .	. .	. .	. .	. .	. .	. .	. .	89	89	89	85	. .	. .
107	USA	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .
108	Greece	. .	. .	. .	. .	. .	. .	. .	. .	. .	56	. .	96	76	. .	. .
109	Ireland	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	65	81	78	. .	. .
110	Singapore	100	100	0	99	99	. .	100	100	. .	99	85	85	90	. .	. .
111	Belgium	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	94	95	75	. .	. .
112	Australia	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	90	90	68	. .	. .
113	Italy	. .	. .	. .	. .	. .	. .	. .	. .	. .	4	83	63	43	. .	. .
114	New Zealand	97	100	82	. .	. .	. .	. .	. .	. .	20	90	90	90	. .	. .
115	Korea, Rep. of	100	100	100	100	100	100	93	97	86	76	80	79	96	. .	. .
116	Canada	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	85[x]	85[x]	85[x]	. .	. .
117	Germany	. .	. .	. .	. .	. .	. .	. .	. .	. .	84	94	94	59	. .	. .
118	Denmark	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	95	97	84	. .	. .
119	Switzerland	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	98	94	. .	. .
120	France	. .	. .	. .	. .	. .	. .	. .	. .	. .	80	95	90	69	. .	. .
121	United Kingdom	. .	. .	. .	. .	. .	. .	. .	. .	. .	75	85	90	89	. .	. .
122	Austria	. .	. .	. .	. .	. .	. .	. .	. .	. .	97	95	95	74	. .	. .
123	Spain	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	73	73	84	. .	. .
124	Hong Kong	100	100	96	. .	100	. .	99[x]	. .	. .	94	90	90	42	. .	. .
125	Netherlands	. .	. .	. .	. .	. .	. .	. .	. .	. .	. .	97	97	94	. .	. .
126	Norway	. .	. .	. .	. .	. .	. .	. .	. .	. .	95	86	84	87	. .	. .
127	Finland	. .	. .	. .	. .	. .	. .	. .	. .	. .	91	90	90	95	. .	. .
128	Japan	. .	. .	. .	. .	. .	. .	. .	. .	. .	85	90	90[x]	73	. .	. .
129	Sweden	. .	. .	. .	. .	. .	. .	. .	. .	. .	14	99	99	84	. .	. .
Regional summaries																
Least developed countries		47	61	42	29	57	22	45	. .	. .	68	51	51	48	42	35
Developing countries		72	84	65	39	71	22	75	. .	. .	84	78	79	76	57	40
Developed countries		. .	. .	. .	. .	. .	. .	. .	. .	. .	82	82	84	80	. .	. .
Sub-Saharan Africa		44	60	37	43	69	32	52	. .	. .	63	48	48	47	31	43
Middle East & North Africa		75	93	56	67	89	37	77	. .	. .	82	81	80	77	48	51
South Asia		80	85	78	17	53	4	52	. .	. .	90	83	83	79	73	19
East Asia & Pacific		71	85	65	58	73	51	87	. .	. .	93	90	91	89	53	49
Latin America & Caribbean		80	89	57	62	81	18	72	. .	. .	62	72	87	77	47	58

Countries listed in descending order of U5MR. Figures in coloured bands are totals or ***weighted*** *averages.*

TABLE 4: EDUCATION

		Adult literacy rate				No. of sets per 1000 population 1989		Primary school enrolment ratio						% of grade 1 enrolment reaching final grade of primary school 1988	Secondary school enrolment ratio 1986-90 (gross)	
		1970		1990				1960 (gross)		1986-90 (gross)		1986-90 (net)				
		male	female	male	female	radio	television	male	female	male	female	male	female		male	female
Very high U5MR countries		**30**	**14**	**59**	**37**	**128**	**17**	**39**	**19**	**73**	**54**	**52**	**41**	**55**	**22**	**13**
1	Angola	16	7	56	29	53	6	..	..	101	85	..	..	24x	17	9
2	Mozambique	29	14	45	21	41	2	60	36	76	59	49	41	39	7	4
3	Afghanistan	13	2	44	14	104	8	15	2	31	16	..	..	63	11	5
4	Sierra Leone	18	8	31	11	220	10	30	..	65	40	..	..	..	23	11
5	Guinea-Bissau	13	6	50	24	39	..	..	..	76	42	52	29	8	9	4
6	Guinea	21	7	35	13	41	5	44	16	46	21	34	17	44	14	5
7	Malawi	42	18	..	..	237	..	..	45	73	60	52	49	47	6	3
8	Mali	11	4	41	24	39	0	14	6	29	17	23	14	40	9	4
9	Niger	6	2	40	17	59	4	7	3	36	20	..	..	75	8	3
10	Chad	20	2	42	18	237	1	29	4	79	35	52	23	71	12	3
11	Ethiopia	8	..	..	..	188	2	11	3	46	30	32	24	44	17	12
12	Somalia	5	1	36	14	41	14	13	13	20	10	14	8	37	13	7
13	Mauritania	..	..	47	21	143	23	13	3	60	42	..	..	68	22	10
14	Burkina Faso	13	3	28	9	26	5	12	5	44	27	34	20	64	9	5
15	Bhutan	..	..	51	25	15	..	5	..	31	20	..	..	26	7	2
16	Zambia	66	37	81	65	74	25	51	34	99	91	81	79	64	25	14
17	Liberia	27	8	50	29	225	18	45	18	43	24	..	..	..	..	..
18	Uganda	52	30	62	35	99	8	..	32	76	63	57	50	76	16	8
19	Rwanda	43	21	64	37	59	..	..	..	69	68	65	65	36	9	6
20	Nigeria	35	14	62	40	171	29	46	27	77	63	..	..	52	22	16
21	Cambodia	..	23	48	22	107	8	..	..	..	..	..	..	50x	45	20
22	Senegal	18	5	52	25	113	35	36	..	67	49	55	41	85	21	11
23	Yemen	14	3	53	26	59	27	..	..	132	39	..	..	53	42	7
24	Burundi	29	10	61	40	57	1	27	9	77	60	55	46	83	5	3
25	Zaire	61	22	84	61	101	1	88	32	89	67	67	53	73	32	16
26	Central African Rep.	26	6	52	25	61	3	53	12	79	48	56	37	48	16	6
27	Tanzania	48	18	93x	88x	21	1	33	18	64	63	47	48	75	5	4
28	Madagascar	56	43	88	73	198	20	58	45	94	90	64	63	32	20	18
29	Sudan	28	6	43	12	235	61	35	14	58x	41x	23	17	76x	23x	17x
30	Gabon	43	22	74	49	138	36	..	..	..	..	..	..	44x	..	..
31	Benin	23	8	32	16	89	5	38	15	87	44	69	36	40	23	9
32	Lao, Peo. Dem.	37	28	..	..	124	5	34	16	122	98	..	..	38	31	22
33	Nepal	23	3	38	13	33	2	19	1	112	57	84	43	27	42	17
34	Togo	27	7	56	31	210	6	63	24	126	80	85	58	46	33	10
35	Iraq	50	18	70	49	202	68	94	36	104	87	90	78	58	58	37
High U5MR countries		**50**	**25**	**65**	**41**	**113**	**39**	**77**	**42**	**103**	**82**	**..**	**..**	**59**	**49**	**31**
36	Lesotho	49	74	..	..	68	3	63	102	99	115	64	76	50	21	31
37	Haiti	26x	17x	59	47	42	5	50	42	86	81	44	44	9	20	19
38	Ghana	43	18	70	51	295	15	52	25	82	67	..	..	87	49	30
39	Pakistan	30	11	47	21	86	16	46	13	49	27	..	..	51	28	12
40	Bangladesh	36	12	47	22	41	4	66	26	76	64	67	58	46	23	11
41	Côte d'Ivoire	26	10	67	40	139	59	68	24	82	58	..	..	73	27	12
42	India	47	20	62	34	78	27	80	40	112	82	..	..	53	54	31
43	Cameroon	47	19	66	43	131	22	87	43	108	93	80	69	68	31	20
44	Bolivia	68	46	85	71	597	98	78	50	86	77	88	78	50	36	31
45	Namibia	..	..	..	..	133	16	..	..	..	..	..	..	..	..	..
46	Myanmar	85	57	89	72	81	2	61	52	106	100	..	..	33x	25	23
47	Congo	50	19	70	44	109	5	103	53	..	..	..	..	62	37	14
48	Libyan Arab Jamahiriya	60	13	75	50	224	91	92	24	..	..	..	..	82x	..	..
49	Peru	81	60	92	79	251	95	95	71	125	120	..	..	70x	68	61
50	Guatemala	51	37	63	47	64	45	50	39	82	70	..	..	36	21	19
51	Morocco	34	10	61	38	209	70	67	27	81	55	65	46	63	42	30
52	Turkey	69	34	90	71	161	174	90	58	117	108	..	..	97	63	39
53	Zimbabwe	63	47	74	60	85	27	..	..	130	126	100	100	74x	49	42
54	Indonesia	66	42	84	62	144	55	86	58	120	115	100	97	79	52	43
55	Botswana	37	44	84	65	111	12	35	48	112	117	94	100	95	31	36
56	Egypt	50	20	63	34	322	98	80	52	104	89	..	..	95	91	71
57	Ecuador	75	68	88	84	314	82	87	79	118	117	..	..	63	55	57
58	Mongolia	87	74	..	..	131	38	79	78	100	103	..	..	..	88	96
59	Nicaragua	58	57	..	..	247	61	65	66	90	100	71	76	29	28	46
60	Papua New Guinea	39	24	65	38	69	2	59	7	79	67	78	67	61	16	10
61	Dominican Rep.	69	65	85	82	168	82	99	98	95	96	..	78	33	..	..
62	Kenya	44	19	80	59	95	9	64	30	96	92	..	..	62	27	19
63	Honduras	55	50	76	71	384	70	68	67	108	109	89	94	43	28	36
64	South Africa	..	..	..	..	324	101	94	85	..	..	..	..	..	..	..
Middle U5MR countries		**84**	**80**	**85**	**68**	**277**	**10[illegible]**	**93**	**88**	**124**	**115**	**98**	**96**	**75**	**51**	**45**
65	Brazil	69	63	83	80	373	204	97	93	..	..	..	..	22x	32	42
66	El Salvador	61	53	76	70	403	87	..	..	77	78	69	71	27	26	2[illegible]
67	Iran, Islamic Rep. of	40	17	65	43	245	66	56	27	115	101	99	90	91	62	44
68	Algeria	39	11	70	46	232	73	55	37	103	88	97	81	90	61	53
69	Paraguay	85x	75x	92	88	169	48	105	90	108	104	93	92	57	28	30
70	Tunisia	44	17	74	56	188	75	88	43	123	107	99	90	79	50	39

		Adult literacy rate				No. of sets per 1000 population 1989		Primary school enrolment ratio						% of grade 1 enrolment reaching final grade of primary school 1985-88	Secondary school enrolment ratio 1986-90 (gross)	
		1970		1990				1960 (gross)		1986-90 (gross)		1986-90 (net)				
		male	female	male	female	radio	television	male	female	male	female	male	female		male	female
71	Viet Nam	..	..	92	84	107	38	..	..	105	99	..	..	57	43	40
72	Syria	60	20	78	51	248	59	89	39	114	102	100	93	85	63	45
73	Jordan	64	29	89	70	252	77	94	59	98	99	88	88	96*	80	78
74	Lebanon	79*	58*	88	73	834	327	105	99	105	95	..	..	..	57	56
75	Philippines	84	81	90	90	136	41	98	93	111	110	100	98	71	72	75
76	Venezuela	79	71	87	90	432	156	100	100	105	105	107	88	70	50	62
77	Saudi Arabia	15	2	73	48	280	277	22	..	81	70	64	48	90	53	39
78	Oman	..	..	..	..	645	762	..	..	106	97	86	81	91	55	40
79	Mexico	78	69	90	85	242	127	82	77	118	115	..	..	70	53	53
80	Romania	96	91	..	..	195	194	101	95	96	95	..	..	94	84	92
81	Korea, Dem. Peo. Rep.	..	..	..	..	117	14	..	..	110	103	..	..	99	100	100
82	Thailand	86	72	96	90	182	109	88	79	89	88	..	..	59	32	29
83	USSR (former)	98	97	..	..	685	323	100	100	104	105	..	..	94	..	..
84	Albania	..	..	..	..	172	83	102	86	99	98	..	..	91	86	73
85	Panama	81	81	88	88	222	165	98	94	109	105	90	89	79	56	63
86	United Arab Emirates	24	7	58	38	322	109	..	..	111	110	100	100	96	60	69
87	Mauritius	77	59	..	..	354	215	103	93	102	104	92	94	98	53	53
88	China	..	..	84	62	184	27	..	..	142	128	100	100	81	50	38
89	Uruguay	93*	93*	97	96	600	227	111	111	107	106	..	..	93	68	76
90	Argentina	94	92	96	95	673	219	98	99	107	114	..	..	..	69	78
91	Trinidad and Tobago	95	89	..	..	460	301	..	..	95	98	89	93	89	81	84
92	Yugoslavia (former)	92	76	97	88	245	197	113	108	95	94	..	..	98*	82	79
93	Bulgaria	94	89	..	..	436	249	94	92	98	96	86	85	62	74	76
94	Chile	90	88	94	93	340	201	111	107	99	97	..	..	77	72	78
95	Sri Lanka	85	69	93	84	194	32	100	90	109	106	100	100	94	71	76
96	Colombia	79	76	88	86	167	108	77	77	106	108	72	74	56	52	53
Low U5MR countries		**97**	**95**	**..**	**..**	**1148**	**521**	**108**	**106**	**103**	**103**	**97**	**98**	**95**	**90**	**92**
97	Malaysia	71	48	87	70	428	144	108	83	97	96	..	..	96	58	59
98	Jamaica	96	97	98	99	409	124	92	93	104	105	98	100	85	62	68
99	Costa Rica	88	87	93	93	259	136	97	95	101	99	86	86	77	41	42
100	Hungary	98	98	..	..	592	409	103	100	96	97	93	94	94	70	72
101	Poland	98	97	..	..	428	292	110	107	99	99	97	98	92	80	83
102	Kuwait	65	42	77	67	337	281	131	102	101	99	..	77	90	93	87
103	Cuba	86	87	95	93	343	203	109	109	105	100	96	95	88	84	94
104	Czechoslovakia	..	..	..	..	583	410	93	93	92	93	..	..	93	84	90
105	Israel	93	83	..	..	468	266	99	97	92	95	..	..	78	79	86
106	Portugal	78	65	89	82	216	176	132	129	131	123	..	..	..	47	56
107	USA	99	99	..	..	2122	814	..	..	101	100	95	96	90	98	99
108	Greece	93	76	98	89	419	195	104	101	101	102	97	98	100	99	94
109	Ireland	..	..	..	..	583	271	107	112	100	101	88	90	97	93	102
110	Singapore	92	55	..	..	306	372	121	113	111	109	100	100	100	68	71
111	Belgium	99	99	..	..	776	447	111	108	101	101	96	97	78	103	104
112	Australia	..	..	..	..	1262	484	103	103	106	105	97	98	99	80	83
113	Italy	95	93	98	96	794	423	112	109	96	96	97	98	100	78	78
114	New Zealand	..	..	..	..	922	372	110	106	106	106	100	100	95	87	89
115	Korea, Rep. of	94	81	99	94	1003	207	99	89	107	110	100	100	100	88	85
116	Canada	..	..	..	..	1023	626	108	105	105	105	96	97	96	104	105
117	Germany	..	..	..	..	895*	378*	..	..	103	102	..	..	99*	92	88
118	Denmark	..	..	..	..	1012	528	103	103	97	98	..	..	99	106	107
119	Switzerland	..	..	..	..	851	406	118	118	..	..	..	..	99*	..	..
120	France	99	98	..	..	895	400	144	143	114	111	100	100	96	93	100
121	United Kingdom	..	..	..	..	1145	434	92	92	105	106	97	97	..	82	85
122	Austria	..	..	..	..	622	475	106	104	104	103	..	..	97	81	83
123	Spain	93	87	97	93	304	389	106	116	112	110	100	100	94	100	111
124	Hong Kong	..	..	..	..	634	260	93	79	105	104	..	95	98	71	75
125	Netherlands	..	..	..	..	902	485	105	104	114	117	100	100	94	105	102
126	Norway	..	..	..	..	796	423	100	100	98	98	98	97	100	96	101
127	Finland	..	..	..	..	998	488	100	95	99	99	..	..	100	103	121
128	Japan	99	99	..	..	895	610	103	102	102	102	100	100	100	94	97
129	Sweden	..	..	..	..	885	471	95	96	104	104	100	100	100	89	93
Regional summaries																
Least developed countries		36	18	58	36	93	8	44	23	74	57	54	44	52	21	12
Developing countries		53	33	75	55	174	51	75	49	108	92	87	82	64	47	35
Developed countries		98	96	..	..	1029	482	106	105	103	103	97	98	94	91	93
Sub-Saharan Africa		34	17	64	44	145	22	49	28	75	60	53	45	58	21	13
Middle East & North Africa		47	19	70	46	237	106	72	41	103	86	81	70	85	61	43
South Asia		44	19	59	32	76	23	74	36	99	72	..	..	52	47	27
East Asia & Pacific		76	56	85	66	196	40	87	69	130	120	..	..	77	51	42
Latin America & Caribbean		76	69	87	83	335	156	91	86	108	107	83	79	47	46	51

Countries listed in descending order of U5MR. Figures in coloured bands are totals or ***weighted*** *averages.*

TABLE 5: DEMOGRAPHIC INDICATORS

		Population (millions) 1991		Population annual growth rate (%)		Crude death rate		Crude birth rate		Life expectancy		Total fertility rate 1991	% of population urbanized 1991	Average annual growth rate of urban population (%)	
		under 16	under 5	1965-80	1980-91	1960	1991	1960	1991	1960	1991			1965-80	1980-91
Very high U5MR countries		**276**	**106**	**2.6**	**3.0**	**26**	**16**	**50**	**47**	**39**	**50**	**6.6**	**25**	**5.9**	**5.3**
1	Angola	5.5	2.2	2.8	2.9	31	20	49	51	33	46	7.2	27	6.4	5.9
2	Mozambique	7.7	2.9	2.5	1.7	26	18	47	45	37	47	6.5	25	11.8	8.8
3	Afghanistan	9.7	4.2	2.4	1.0	30	22	52	52	33	43	6.9	18	6.0	2.6
4	Sierra Leone	2.2	0.9	2.0	2.4	33	22	48	48	32	42	6.5	31	4.3	5.1
5	Guinea-Bissau	0.5	0.2	1.2	2.0	29	22	40	43	34	43	5.8	19	1.7	3.6
6	Guinea	3.3	1.3	1.9	2.6	31	21	53	51	34	44	7.0	25	6.6	5.6
7	Malawi	5.8	2.3	2.9	4.3	28	21	54	55	38	45	7.6	11	7.8	6.9
8	Mali	5.4	2.1	2.1	3.0	29	20	52	51	35	45	7.1	23	4.9	5.6
9	Niger	4.6	1.8	2.7	3.3	29	19	53	51	35	46	7.1	19	6.9	7.2
10	Chad	2.9	1.1	2.0	2.2	30	18	46	44	35	47	5.9	30	9.2	6.5
11	Ethiopia	28.2	11.2	2.7	2.6	28	19	50	49	36	46	7.0	12	6.6	4.2
12	Somalia	5.1	2.0	2.7	2.6	28	19	50	50	36	46	7.0	24	6.1	3.6
13	Mauritania	1.1	0.4	2.3	2.7	28	18	48	46	35	47	6.5	44	12.4	7.3
14	Burkina Faso	4.9	1.9	2.0	2.6	28	18	49	47	36	48	6.5	14	3.4	8.5
15	Bhutan	0.7	0.3	1.6	2.2	26	17	42	40	37	48	5.9	5	3.7	5.3
16	Zambia	4.8	1.8	3.1	3.5	22	17	50	47	42	45	6.5	42	7.1	4.0
17	Liberia	1.5	0.6	3.0	3.2	25	15	50	47	41	55	6.8	44	6.2	5.8
18	Uganda	10.4	4.1	2.9	2.9	21	21	50	51	43	43	7.3	11	4.1	5.4
19	Rwanda	4.3	1.7	3.3	3.1	22	18	50	52	42	47	8.5	5	6.3	4.8
20	Nigeria	62.5	23.4	2.5	3.3	24	14	52	46	40	52	6.6	34	4.8	5.9
21	Cambodia	4.1	1.5	0.3	2.5	21	15	45	40	42	50	4.5	11	1.9	3.8
22	Senegal	3.9	1.5	2.5	2.8	27	17	50	44	37	49	6.2	39	4.1	3.9
23	Yemen	7.2	2.7	2.3	3.5	28	14	53	49	36	52	7.3	28	6.4	7.1
24	Burundi	3.1	1.2	1.9	2.9	23	17	46	46	41	48	6.8	5	1.8	5.1
25	Zaire	22.1	8.6	2.8	3.3	23	15	47	48	41	52	6.7	28	7.2	3.1
26	Central African Rep.	1.6	0.6	1.8	2.6	26	18	43	45	39	47	6.2	46	4.8	4.6
27	Tanzania	15.4	6.0	3.3	3.4	23	15	51	48	41	51	6.8	20	8.7	6.8
28	Madagascar	6.8	2.6	2.5	3.2	24	13	48	46	41	55	6.6	23	5.7	5.8
29	Sudan	13.5	5.0	3.0	3.0	25	15	47	43	39	51	6.2	22	5.1	4.3
30	Gabon	0.5	0.2	3.5	3.6	24	16	31	41	41	53	5.2	44	4.2	6.0
31	Benin	2.7	1.1	2.7	2.9	33	18	47	49	35	46	7.1	37	10.2	4.8
32	Lao, Peo. Dem.	2.3	0.9	0.6	2.8	23	16	45	45	40	50	6.7	18	4.8	6.0
33	Nepal	10.0	3.4	2.4	2.7	26	14	46	39	38	53	5.6	10	5.1	7.9
34	Togo	2.0	0.8	3.0	3.0	26	13	48	45	39	54	6.6	28	7.2	5.2
35	Iraq	9.8	3.6	3.4	3.3	20	7	49	39	48	66	5.8	71	5.3	4.2
High U5MR countries		**707**	**244**	**2.5**	**2.3**	**21**	**10**	**44**	**32**	**44**	**58**	**4.2**	**30**	**4.1**	**3.8**
36	Lesotho	0.8	0.3	2.3	2.7	24	10	43	35	43	60	4.8	19	14.6	6.5
37	Haiti	3.0	1.1	2.0	1.9	23	12	42	36	42	56	4.9	28	4.0	3.8
38	Ghana	8.3	3.0	2.2	3.3	19	12	48	42	45	55	6.1	34	3.4	4.3
39	Pakistan	61.8	22.5	3.1	3.2	23	11	49	42	43	58	6.3	31	4.3	4.6
40	Bangladesh	54.5	19.7	2.7	2.5	22	14	47	39	40	52	4.8	16	8.0	6.3
41	Côte d'Ivoire	7.4	2.9	4.2	3.8	25	15	53	50	39	52	7.4	40	8.7	5.3
42	India	343.7	115.9	2.3	2.1	21	10	43	30	44	60	4.0	25	3.6	3.1
43	Cameroon	6.1	2.3	2.7	2.9	24	13	44	41	39	55	5.8	39	8.1	5.4
44	Bolivia	3.4	1.2	2.5	2.5	22	10	46	35	43	60	4.7	50	2.9	3.9
45	Namibia	0.8	0.3	1.0	3.0	22	11	45	43	42	58	6.0	27	1.9	5.1
46	Myanmar	18.4	6.5	2.3	2.1	21	12	42	33	44	57	4.3	25	2.8	2.5
47	Congo	1.2	0.5	2.7	2.9	23	15	45	45	42	52	6.3	40	3.5	4.2
48	Libyan Arab Jamahiriya	2.6	1.0	4.6	4.0	19	8	49	43	47	62	6.5	81	9.7	5.6
49	Peru	9.0	3.0	2.8	2.2	19	8	47	30	48	64	3.7	69	4.1	3.0
50	Guatemala	5.0	1.8	2.8	2.9	19	8	49	39	46	64	5.5	39	3.6	3.5
51	Morocco	11.6	4.0	2.5	2.6	21	9	50	33	47	63	4.5	45	4.2	3.7
52	Turkey	22.2	7.8	2.4	2.3	18	7	45	29	50	67	3.6	59	4.3	5.5
53	Zimbabwe	5.4	2.0	3.1	3.3	20	11	53	41	45	56	5.5	28	7.5	5.8
54	Indonesia	71.5	23.5	2.3	2.0	23	9	44	27	41	62	3.2	28	4.7	4.6
55	Botswana	0.7	0.2	3.5	3.2	20	10	52	39	46	60	5.2	24	15.4	8.2
56	Egypt	23.5	7.8	2.4	2.5	21	10	45	32	46	61	4.2	44	2.9	2.5
57	Ecuador	4.6	1.5	3.1	2.6	15	7	46	30	53	66	3.8	55	5.1	4.4
58	Mongolia	1.1	0.4	3.0	2.8	18	8	43	35	47	63	4.7	57	4.5	3.8
59	Nicaragua	2.1	0.8	3.1	2.8	19	7	51	41	47	65	5.2	59	4.6	4.0
60	Papua New Guinea	1.8	0.6	2.3	2.3	23	11	44	34	41	55	5.0	15	8.4	4.3
61	Dominican Rep.	3.0	1.0	2.7	2.3	16	6	50	29	52	67	3.5	59	5.3	4.0
62	Kenya	13.9	5.2	3.6	3.5	22	11	53	44	45	59	6.4	23	9.0	7.3
63	Honduras	2.7	1.0	3.2	3.4	19	7	51	38	46	65	5.1	43	5.5	5.3
64	South Africa	16.9	5.8	2.4	2.5	17	9	42	32	49	62	4.2	49	2.6	2.8
Middle U5MR countries		**739**	**243**	**2.1**	**1.6**	**16**	**7**	**36**	**23**	**52**	**68**	**2.7**	**41**	**3.2**	**3.3**
65	Brazil	55.3	16.9	2.4	2.0	13	7	43	24	55	66	2.9	74	4.5	3.3
66	El Salvador	2.5	0.9	2.7	1.4	16	8	48	34	50	65	4.2	44	3.5	2.1
67	Iran, Islamic Rep. of	32.2	11.6	3.2	3.9	21	7	47	41	50	67	6.1	56	5.5	5.2
68	Algeria	12.5	4.3	3.1	2.9	20	7	51	34	47	66	5.0	51	3.8	4.6
69	Paraguay	2.0	0.7	2.8	3.0	9	6	43	34	64	67	4.4	47	3.2	4.4
70	Tunisia	3.3	1.1	2.1	2.3	19	7	47	28	48	67	3.6	55	4.2	3.4

		Population (millions) 1991		Population annual growth rate (%)		Crude death rate		Crude birth rate		Life expectancy		Total fertility rate	% of population urbanized	Average annual growth rate of urban population (%)	
		under 16	under 5	1965-80	1980-91	1960	1991	1960	1991	1960	1991	1991	1991	1965-80	1980-91
71	Viet Nam	28.9	9.6	1.0	2.2	23	9	41	30	44	63	4.0	20	4.1	2.5
72	Syria	7.4	2.7	3.4	3.5	18	6	47	43	50	66	6.3	50	4.5	4.3
73	Jordan	2.2	0.8	2.6	3.2	23	6	50	39	47	67	5.8	67	5.3	4.5
74	Lebanon	1.1	0.4	1.6	0.4	14	7	43	27	60	68	3.2	82	4.6	1.7
75	Philippines	26.1	9.4	2.9	2.5	15	7	45	31	53	65	4.0	42	4.0	3.8
76	Venezuela	7.9	2.6	3.5	2.5	10	5	45	27	60	70	3.2	90	4.5	3.3
77	Saudi Arabia	7.8	2.8	4.6	4.5	23	5	49	36	44	69	6.5	76	8.5	5.9
78	Oman	0.9	0.3	3.6	4.3	28	5	51	41	40	69	6.8	11	8.1	8.1
79	Mexico	35.7	11.9	3.1	2.3	13	6	45	29	57	70	3.3	72	4.5	3.2
80	Romania	5.6	1.8	1.1	0.4	9	11	20	16	65	70	2.2	53	3.4	1.3
81	Korea, Dem. Peo. Rep.	7.3	2.7	2.7	1.8	13	5	42	24	54	71	2.4	60	4.6	2.3
82	Thailand	18.2	5.6	2.7	1.5	15	6	44	21	52	69	2.3	21	4.6	4.2
83	USSR (former)	77.1	22.9	0.9	0.8	7	10	24	17	68	70	2.3	66	2.2	1.4
84	Albania	1.1	0.4	2.5	1.9	10	5	41	24	62	73	2.8	35	3.4	2.5
85	Panama	0.9	0.3	2.6	2.1	10	5	41	25	61	73	3.0	52	3.4	2.7
86	United Arab Emirates	0.5	0.2	16.1	4.3	19	4	46	22	53	71	4.6	80	18.9	5.5
87	Mauritius	0.3	0.1	1.6	1.1	10	7	44	19	59	70	2.0	41	4.0	0.7
88	China	357.2	120.4	2.2	1.5	19	7	37	21	47	70	2.3	25	2.6	4.4
89	Uruguay	0.8	0.3	0.4	0.6	10	10	22	17	68	72	2.4	88	0.7	1.0
90	Argentina	10.4	3.3	1.6	1.3	9	9	24	21	65	71	2.8	86	2.2	1.7
91	Trinidad and Tobago	0.5	0.1	1.3	1.3	9	6	38	24	63	71	2.8	65	5.0	1.6
92	Yugoslavia (former)	5.6	1.6	0.9	0.6	10	9	23	14	63	72	1.9	55	3.0	2.7
93	Bulgaria	1.8	0.5	0.5	0.1	9	12	18	13	68	72	1.9	67	2.8	1.1
94	Chile	4.6	1.5	1.8	1.7	13	6	37	23	57	72	2.7	84	2.6	2.1
95	Sri Lanka	5.9	1.8	1.8	1.5	9	6	36	21	62	71	2.5	21	2.3	1.5
96	Colombia	12.3	3.9	2.2	1.9	12	6	45	25	57	69	2.7	69	3.5	2.8
Low USMR countries		**213**	**67**	**0.9**	**0.7**	**10**	**9**	**21**	**14**	**68**	**76**	**1.8**	**75**	**1.7**	**1.0**
97	Malaysia	8.0	2.7	2.5	2.6	15	5	44	30	54	70	3.7	42	4.5	4.8
98	Jamaica	0.8	0.3	1.5	1.2	9	6	39	23	63	73	2.5	51	3.4	2.4
99	Costa Rica	1.3	0.4	2.6	2.8	10	4	47	27	62	76	3.2	47	3.7	3.7
100	Hungary	2.1	0.6	0.4	-0.1	10	14	16	12	68	70	1.8	63	1.8	1.0
101	Poland	9.8	2.7	0.8	0.7	8	10	24	15	67	71	2.1	61	1.8	1.3
102	Kuwait	0.7	0.2	7.0	3.6	10	2	44	28	60	75	3.8	95	8.2	4.1
103	Cuba	2.7	0.9	1.5	0.9	9	7	31	17	64	76	1.9	73	2.7	1.7
104	Czechoslovakia	3.6	1.1	0.5	0.2	10	11	17	14	70	72	2.0	76	1.9	1.5
105	Israel	1.8	0.6	2.8	2.1	6	7	27	22	69	76	2.9	91	3.5	2.5
106	Portugal	2.0	0.6	0.6	0.1	11	10	24	12	63	74	1.5	33	2.0	1.4
107	USA	61.2	20.3	1.0	0.9	9	9	23	16	70	76	2.0	75	1.2	1.1
108	Greece	1.9	0.5	0.7	0.5	8	10	19	10	69	77	1.5	62	2.5	1.3
109	Ireland	0.9	0.2	1.2	0.3	12	9	21	15	70	75	2.2	57	2.2	0.6
110	Singapore	0.7	0.2	1.6	1.1	8	5	38	16	64	74	1.7	100	1.6	1.1
111	Belgium	1.9	0.6	0.3	0.1	12	11	17	12	70	76	1.6	96	0.5	0.2
112	Australia	4.2	1.4	1.8	1.5	9	8	22	15	71	77	1.9	85	0.2	1.4
113	Italy	9.6	2.9	0.6	0.2	10	10	18	10	69	77	1.3	69	1.0	0.6
114	New Zealand	0.9	0.3	1.3	0.9	9	8	26	17	71	75	2.1	84	1.5	0.9
115	Korea, Rep. of	11.3	3.5	1.9	1.2	14	6	43	16	54	70	1.7	70	5.7	3.6
116	Canada	6.3	2.0	1.3	1.1	8	8	26	14	71	77	1.8	77	1.5	1.3
117	Germany	14.8	4.6	0.2	0.2	12	11	17	11	70	76	1.5	85	0.9	0.5
118	Denmark	0.9	0.3	0.5	0.1	9	12	17	12	72	75	1.7	85	1.1	0.2
119	Switzerland	1.3	0.4	0.5	0.6	10	10	18	12	71	78	1.6	61	1.2	1.4
120	France	12.2	3.8	0.7	0.5	12	10	18	14	70	77	1.8	73	2.7	0.4
121	United Kingdom	12.1	4.0	0.2	0.2	12	11	17	14	71	76	1.9	89	0.5	0.2
122	Austria	1.5	0.5	0.3	0.2	12	11	18	12	69	76	1.5	58	0.1	0.9
123	Spain	7.3	2.1	1.0	0.4	9	9	21	11	69	77	1.4	78	2.4	1.1
124	Hong Kong	1.2	0.4	2.1	1.2	7	6	35	13	66	77	1.4	94	2.3	1.5
125	Netherlands	3.1	1.0	0.9	0.6	8	9	21	13	73	77	1.7	89	1.5	0.6
126	Norway	0.9	0.3	0.6	0.4	9	11	18	14	73	77	1.9	74	5.0	1.0
127	Finland	1.0	0.3	0.3	0.4	9	10	19	13	68	75	1.8	60	2.5	0.4
128	Japan	22.8	6.9	1.2	0.5	8	7	18	11	68	79	1.7	77	2.1	0.7
129	Sweden	1.7	0.6	0.5	0.3	10	11	15	14	73	78	2.0	84	1.0	0.4
Regional summaries															
Least developed countries		270	102	2.6	2.7	25	16	48	44	39	50	6.0	19	6.4	5.2
Developing countries		165	574	2.4	2.1	20	9	42	30	46	61	3.7	33	4.0	3.9
Developed countries		277	86	0.8	0.6	9	10	21	14	69	74	1.9	73	1.7	1.0
Sub-Saharan Africa		281	107	2.7	3.0	24	15	49	46	40	51	6.5	28	5.7	5.2
Middle East & North Africa		159	56	2.9	3.0	21	8	47	36	47	63	5.0	52	4.9	4.6
South Asia		486	168	2.4	2.2	21	11	44	33	43	58	4.4	24	3.9	3.5
East Asia & Pacific		560	188	2.2	1.7	19	7	39	23	47	68	2.6	28	3.3	4.1
Latin America & Caribbean		171	55	2.5	2.1	13	7	42	26	56	67	3.2	71	4.0	3.0

Countries listed in descending order of U5MR. Figures in coloured bands are totals or ***weighted*** *averages.*

TABLE 6: ECONOMIC INDICATORS

		GNP per capita (US$)	GNP per capita average annual growth rate (%)		Rate of inflation (%)	% of population below absolute poverty level 1980-89		% of central government expenditure allocated to (1986-91)			ODA inflow in millions US$	ODA inflow as a % of recipient GNP	Debt service as a % of exports of goods and services	
		1990	1965-80	1980-90	1980-90	urban	rural	health	education	defence	1990	1990	1970	1990
Very high U5MR countries		**355**	**2.4**	**-0.8**	**24**	**. .**	**. .**	**3**	**9**	**. .**	**12723**	**12**	**5**	**15**
1	Angola	610^{x}	. .	6.1	. .	. .	. .	6	15	34	211	. .	. .	. .
2	Mozambique	80	. .	-4.1	37	50	67	5	10	35	923	76	. .	5
3	Afghanistan	280^{x}	0.6	. .	. .	18^{x}	36^{x}	. .	. .	. .	172	. .	. .	. .
4	Sierra Leone	240	0.7	-1.5	56	. .	65^{x}	8^{x}	16^{x}	4^{x}	66	7	11	6^{x}
5	Guinea-Bissau	180	-2.7	1.7	. .	. .	. .	1	3	4	118	67	. .	27
6	Guinea	480	1.3	. .	. .	. .	. .		11	29	274	10	. .	6
7	Malawi	200	3.2	-0.1	15	25	85	7	9	5	450	27	8	19
8	Mali	270	2.1^{x}	1.2	3	27^{x}	48^{x}	4	17	17	462	20	1	7
9	Niger	310	-2.5	-4.5	3	. .	35^{x}	. .	. .	. .	357	15	4	4
10	Chad	190	-1.9	3.3	1	30^{x}	56^{x}	8	8	. .	314	29	4	2
11	Ethiopia	120	0.4	-1.2	2	60	65	. .	. .		871	14	11	31
12	Somalia	150	-0.1	-1.8	50	40^{x}	70^{x}	1	2	38	433	46	2	18^{x}
13	Mauritania	500	-0.1	-1.8	9	. .	. .	4	23	. .	207	21	3	8
14	Burkina Faso	330	1.7	1.4	5	. .	. .	5	14	18	305	10	7	5
15	Bhutan	190	. .	7.4	8	. .	. .	5	12	. .	42	15	. .	. .
16	Zambia	420	-1.2	-2.9	42	25		7	9	. .	430	13	6	11
17	Liberia	450^{x}	0.5	5.2^{x}	. .		23^{x}		. .	. .	94	. .	8	. .
18	Uganda	220	-2.2	0.8	107			2	15	26	563	15	3	35
19	Rwanda	310	1.6	-2.2	4	30	90^{x}	5	26	. .	281	13	1	11
20	Nigeria	270	4.2	-3.0	18	. .	. .	1	3	3	214	1	4	20
21	Cambodia		. .	. .	. .	. .	. .	. .	. .	. .	35	. .	. .	. .
22	Senegal	710	-0.5	0.0	7	. .	. .	. .	. .	. .	724	14	3	15
23	Yemen	650^{x}	. .	. .	. .						390	. .	. .	17^{x}
24	Burundi	210	2.4	1.3	4	55^{x}	85^{x}	4	16	16	259	23	2	41
25	Zaire	230	-1.3	-1.5	61	. .	80^{x}	4	6	14	816	10	4	6
26	Central African Rep.	390	0.8	-1.3	5	. .	91	. .	. .	. .	227	19	5	6
27	Tanzania	120	0.8	-0.7	26			6^{x}	8^{x}	16^{x}	1155	42	5	18
28	Madagascar	230	-0.4	-2.3	17	50^{x}	50^{x}	. .	. .	. .	375	14	4	34
29	Sudan	420^{x}	0.8	1.8^{x}	34^{x}	. .	85^{x}	. .	. .	. .	768	. .	11	3
30	Gabon	3330	5.6	-2.6	-2	. .	. .				139	4	6	5
31	Benin	360	-0.3	-1.0	2	. .	. .	6	31	17	254	15	2	5^{x}
32	Lao, Peo. Dem.	200	. .	0.7	. .	. .	. .	. .	. .	. .	150	18	. .	12
33	Nepal	170	. .	1.8	9	55^{x}	61^{x}	5	11	6	383	12	3	14
34	Togo	410	1.7	-1.7	5	42^{x}	. .	5	20	11	205	14	3	10
35	Iraq	2340^{x}	. .	. .	. .	. .	. .	. .	. .	. .	56	. .	. .	. .
High U5MR countries		**525**	**2.6**	**1.8**	**23**	**32**	**37**	**3**	**9**	**15**	**20609**	**3**	**15**	**20**
36	Lesotho	470	6.8	-0.9	13	50^{x}	55^{x}	7	16	10	138	17	5	2
37	Haiti	370	0.9	-2.3	7	65	80	. .	. .	. .	176	7	59	3
38	Ghana	390	-0.8	-0.6	43	59	37	9	26	3	470	8	6	18
39	Pakistan	380	1.8	2.9	7	32^{x}	29^{x}	1	2	28	1108	3	24	17
40	Bangladesh	200	-0.3	1.0	10	86^{x}	86^{x}	5	11	10	2081	9	. .	16
41	Côte d'Ivoire	730	2.8	-3.7	2	30	26	4	. .	. .	674	8	7	13
42	India	350	1.5	3.2	8	29	33	2	3	17	1550	1	22	20
43	Cameroon	940	2.4	-0.3	6	15^{x}	40^{x}	3	12	7	475	4	3	13
44	Bolivia	620	1.7	-2.6	318	. .	. .	2	18	14	499	7	11	29
45	Namibia	1030^{x}	. .	. .	13^{x}	. .	. .	10	22	7	62	. .	. .	. .
46	Myanmar	220^{x}	1.6	. .	. .	40^{x}	40^{x}	5	17	25	196	. .	12	29^{x}
47	Congo	1010	2.7	-0.2	1	. .	. .	. .	. .	. .	208	9	12	15
48	Libyan Arab Jamahiriya	5310^{x}	0.0	-9.2	0	. .		. .	. .	. .	11	. .	. .	. .
49	Peru	1160	0.8	-2.0	234	46	83	5	16	11	386	2	12	5
50	Guatemala	900	3.0	-2.1	15	17	51	10	20	13	191	2	7	10
51	Morocco	950	2.7	1.6	7	28^{x}	45^{x}	3	17	15	965	4	9	19
52	Turkey	1630	3.6	3.0	43	. .	. .	4	19	12	1259	1	22	25
53	Zimbabwe	640	1.7	-0.8	11	. .	. .	8	. .	17	336	5	2	19
54	Indonesia	570	5.2	4.1	8	20	16	2	8	8	1717	2	7	23
55	Botswana	2040	9.9	6.3	12	40	55	5	20	12	151	6	1	4
56	Egypt	600	2.8	2.1	12	34	34	3	13	13	5584	18	38	21
57	Ecuador	960	5.4	-0.8	37	40	65	7	25	12	142	1	9	27
58	Mongolia	780^{x}	. .	. .	-1	. .		. .	. .	. .	11	. .	. .	. .
59	Nicaragua	830^{x}	-0.7	4.7^{x}	432	21^{x}	19^{x}	11	9	50	316	. .	11	3
60	Papua New Guinea	860	. .	-0.5	5	10^{x}	75^{x}	9	15	5	376	11	1	17
61	Dominican Rep.	820	3.8	-0.4	22	45^{x}	43^{x}	10	9	5	93	2	4	6
62	Kenya	370	3.1	0.3	9	10^{x}	55^{x}	5	20	8	989	. .	6	21
63	Honduras	590	1.1	-1.2	5	31	70	. .	. .	7	445	15	3	32
64	South Africa	2530	3.2	-0.9	14	. .	. .	. .	. .	. .	. .	. .	. .	. .
Middle U5MR countries		**1465**	**4.2**	**1.4**	**94**	**. .**	**. .**	**7**	**11**	**10**	**8706**	**1**	**12**	**16**
65	Brazil	2680	6.3	0.6	284	9	34	7	5	4	161	0	13	15
66	El Salvador	1100	1.5	-0.6	17	20	32	8	16	25	344	6	4	20
67	Iran, Islamic Rep. of	2450	2.9	-0.8	14	. .	. .	9	22	14	66	0	. .	. .
68	Algeria	2060	4.2	-0.3	7	20^{x}	. .	. .	. .	. .	225	0	4	58
69	Paraguay	1110	4.1	-1.3	24	19^{x}	50^{x}	4	13	13	50	1	12	12
70	Tunisia	1420	4.7	0.0	7	20^{x}	15^{x}	6	16	7	310	3	20	22

		GNP per capita (US$)	GNP per capita average annual growth rate (%)		Rate of inflation (%)	% of population below absolute poverty level 1980-89		% of central government expenditure allocated to (1986-91)			ODA inflow in millions US$	ODA inflow as a % of recipient GNP	Debt service as a % of exports of goods and services	
		1990	1965-80	1980-90	1980-90	urban	rural	health	education	defence	1990	1990	1970	1990
71	Viet Nam	240^x	..	..	..	..	..	..	..	..	164	..	..	..
72	Syria	990	5.1	-2.1	15			1	9	41	645	5	11	25
73	Jordan	1240	5.8^x	-3.9	..	14^x	17^x	6	14	23	884	23	4	22
74	Lebanon	2150^x	..	..	..	..	..	..	..	..	136	..	..	..
75	Philippines	730	3.2	-1.5	15	52	64	4	17	11	1266	3	8	16
76	Venezuela	2560	2.3	-2.0	19	..	..	10	20	6	76	0	3	17
77	Saudi Arabia	7050	4.0^x	-5.6	-4	..	..	..	..	..	18	..	..	..
78	Oman	5220^x	9.0	7.1	..	..	..	5	11	41	67	..	..	13
79	Mexico	2490	3.6	-0.9	70	..	..	2	14	2	130	0	24	18
80	Romania	1640	..	1.1	2	..	..	9	3	10	..	..	..	..
81	Korea, Dem. Peo. Rep.	970^x	..	..	..	..	..	..	..	..	6	..	..	..
82	Thailand	1420	4.4	5.6	3	10	25	20	7	17	787	1	3	11
83	USSR (former)	4550^x	..	..	..	..	..	..	..	..	..	..	..	..
84	Albania	790^x	..	..	..	..	..	..	..	..	12	..	..	..
85	Panama	1830	2.8	-2.0	2	21^x	30^x	18	19	8	93	2	8	3
86	United Arab Emirates	19860	..	-7.2	1	..	..	7	15	44	4	0	..	..
87	Mauritius	2250	3.7	5.4	9	12^x	12^x	9	14	2	86	4	3	4
88	China	370	4.1	7.9	6	..	13	..	..	8	2064	1	..	9
89	Uruguay	2560	2.5	-0.9	61	22	..	5	7	9	46	1	22	30
90	Argentina	2370	1.7	-1.8	395	..	..	2	9	9	173	0	22	25
91	Trinidad and Tobago	3470	3.1	-6.0	6	..	39^x	..	..	..	10	0	5	13
92	Yugoslavia (former)	3060	5.2	-0.9	123	..	..	..	..	53	46	0	10	7
93	Bulgaria	2250	..	2.3	2	..	..	4	6	7	..	..	..	16
94	Chile	1940	0.0	1.1	21	12	20	6	10	8	89	0	19	15
95	Sri Lanka	470	2.8	2.4	11	..	..	7	10	7	659	8	11	10
96	Colombia	1240	3.7	1.1	25	32	70	..	..	..	89	0	12	33
Low U5MR countries		**17580**	**..**	**2.5**	**5**	**..**	**..**	**13**	**4**	**14**	**2578**	**..**	**..**	**10**
97	Malaysia	2340	4.7	2.5	2	13	38	..	..	..	467	1	4	10
98	Jamaica	1510	-0.1	-0.4	18	..	80	7	11	8	277	8	3	24
99	Costa Rica	1910	3.3	0.6	24	6	20	26	19	2	228	4	10	21
100	Hungary	2780	5.1	1.5	9	..	..	8	3	4	..	..	..	43
101	Poland	1690	..	1.2	54	..	..	..	..	..	..	..	..	4
102	Kuwait	16150^x	0.6^x	-2.2	-3	..	..	8	14	20	4	..	..	..
103	Cuba	1170^x	..	..	..	..	..	23	10	..	29	..	..	..
104	Czechoslovakia	3140	..	1.3	2	..	..	..	2	7	..	..	..	9
105	Israel	10920	3.7	1.5	101	..	..	4	10	25	1374	3	3	..
106	Portugal	4900	4.6	2.4	18	..	..	..	..	6	67	0	7	16
107	USA	21790	1.8	2.2	4	..	..	14	2	23	..	..	..	..
108	Greece	5990	4.8	1.5	18	..	..	..	..	..	35	0	9	..
109	Ireland	9550	2.8	1.1	7	..	..	13	13	3	..	..	..	..
110	Singapore	12310	8.3	5.7	2	..	..	5	18	22	-4	0	1	..
111	Belgium	15540	3.6	1.2	4	..	..	12	2	5	..	..	..	..
112	Australia	17000	2.2	1.7	7	..	..	13	7	9	..	..	..	..
113	Italy	16830	3.2	2.2	10	..	..	11	8	4	..	..	..	..
114	New Zealand	12680	1.7	0.6	10	..	..	12	12	4	..	..	..	..
115	Korea, Rep. of	5400	7.3	8.9	18	18^x	11^x	2	20	26	53	0	20	6
116	Canada	20470	3.3	2.4	4	..	..	6	3	7	..	..	..	..
117	Germany	22320^x	3.0^x	2.2^x	3^x	..	..	19	1	8	..	..	..	..
118	Denmark	22080	2.2	2.1	6	..	..	1	9	5	..	..	..	..
119	Switzerland	32680	1.5	1.7	4	..	..	13^x	3^x	10^x	..	..	..	..
120	France	19490	3.7	1.7	6	..	..	15	7	7	..	..	..	..
121	United Kingdom	16100	2.0	2.5	6	..	..	15	3	12	..	..	..	..
122	Austria	19060	4.0	2.0	4	..	..	13	9	3	..	..	..	..
123	Spain	11020	4.1	2.7	9	..	..	13	6	6	..	..	..	..
124	Hong Kong	11540	6.2	5.5	7	..	..	..	17	..	48	0	..	..
125	Netherlands	17320	2.7	1.4	2	..	..	12	11	5	..	..	..	..
126	Norway	23120	3.6	2.7	6	..	..	10	9	8	..	..	..	..
127	Finland	26040	3.6	3.1	7	..	..	11	14	5	..	..	..	..
128	Japan	25430	5.1	3.5	2	..	..	..	..	..	..	..	..	..
129	Sweden	23660	2.0	1.8	7	..	..	1	9	6	..	..	..	..
Regional summaries														
Least developed countries		240	-0.1	0.1	23	55	70	5	13	16	13894	15	7	10
Developing countries		805	3.7	2.2	62	27	31	5	12	12	43082	2	12	16
Developed countries		14710	..	2.4	5	..	..	14	4	14	1534	..	..	..
Sub-Saharan Africa		490	2.5	-0.9	17	..	62	4	12	11	14316	10	5	14
Middle East & North Africa		1975	3.8	-1.4	12	..	..	6	18	18	11392	2	..	28
South Asia		335	1.5	3.0	8	33	39	2	4	18	5995	2	21	18
East Asia & Pacific		650	..	6.8	9	..	17	..	15	14	7336	1	..	11
Latin America & Caribbean		2105	4.1	-0.3	190	18	49	6	10	5	4043	0	14	18

*Countries listed in descending order of U5MR. Figures in coloured bands are totals or **weighted** averages.*

TABLE 7: WOMEN

		Life expectancy females as a % of males 1991	Adult literacy rate females as a % of males 1990	Enrolment ratios females as a % of males 1986-90		Contraceptive prevalence (%) 1980-92	Pregnant women immunized against tetanus 1990-91	% of births attended by trained health personnel 1983-91	Maternal mortality rate 1980-90
				primary school	secondary school				
Very high U5MR countries		**106**	**62**	**74**	**58**	**6**	**28**	**33**	**640**
1	Angola	107	52	84	53	1^x	36	15	. .
2	Mozambique	107	47	78	57	4	30	25	300
3	Afghanistan	102	32	52	45	2^x	9	9	640
4	Sierra Leone	108	35	62	48	4	77	25	450
5	Guinea-Bissau	108	48	55	44	1^x	35	27	700^x
6	Guinea	102	37	46	36	1^x	25	25	800
7	Malawi	103	. .	82	50	7	76	45	170
8	Mali	107	59	59	44	5	9	32	2000
9	Niger	107	43	56	38	1^x	44	47	700
10	Chad	107	43	44	25	1^x	4	15	960
11	Ethiopia	107	. .	65	71	2	6	14	. .
12	Somalia	107	39	50	54	1	5	2	1100
13	Mauritania	107	45	70	45	4	40	20	. .
14	Burkina Faso	107	32	61	56	1	26	30	810
15	Bhutan	103	49	65	29	2	43	7	1310
16	Zambia	103	80	92	56	1^x	68	38	150
17	Liberia	105	58	56	. .	6	20^x	58	. .
18	Uganda	106	56	83	50	5	21	38	300
19	Rwanda	107	58	99	67	10	88	22	210^x
20	Nigeria	107	65	82	73	6	26	37	800
21	Cambodia	106	46	. .	44	. .	22	47	500
22	Senegal	104	48	73	52	11	33	41	600
23	Yemen	101	49	30	17	. .	8	12	. .
24	Burundi	107	66	78	60	9	56	19	. .
25	Zaire	107	73	75	50	1^x	29	. .	800
26	Central African Rep.	111	48	61	38	. .	87	66	600
27	Tanzania	106	95	98	80	8	40	60	340^x
28	Madagascar	106	83	96	90	. .	17	62	570
29	Sudan	105	28	71^x	74	9	16	69	550
30	Gabon	107	66	. .	. .	. .	86	80	190
31	Benin	107	50	51	39	9	83	45	160^x
32	Lao, Peo. Dem.	106	. .	80	71	. .	.3	. .	. .
33	Nepal	98	34	51	40	14	17	6	830
34	Togo	107	55	63	30	34	81	15	420
35	Iraq	105	70	84	64	18	45	50	120^x
High U5MR countries		**103**	**62**	**80**	**64**	**39**	**65**	**35**	**440**
36	Lesotho	109	. .	116	148	5^x	. .	40	. .
37	Haiti	106	80	94	95	10	23	20	340
38	Ghana	107	73	82	61	13	9	55	1000
39	Pakistan	100	45	55	43	12	42	40	500
40	Bangladesh	99	47	84	48	31	78	5	600
41	Côte d'Ivoire	106	60	71	44	3	35	20	. .
42	India	101	55	73	57	43	80	33	460
43	Cameroon	106	65	86	65	16	35	45	430
44	Bolivia	108	84	90	86	30	52	54	600
45	Namibia	105	. .	. .	. .	26	52	. .	370^x
46	Myanmar	106	81	94	92	13	61	57	460
47	Congo	110	63	. .	38	. .	60	. .	900
48	Libyan Arab Jamahiriya	106	67	. .	. .	. .	18	76	80^x
49	Peru	106	95	96	90	59	12	52	300
50	Guatemala	108	75	85	90	23	18	34	200
51	Morocco	106	62	68	71	36	64	26	300^x
52	Turkey	108	79	92	62	63	20	77	150
53	Zimbabwe	106	81	97	86	43	60	60	. .
54	Indonesia	106	74	96	83	48	52	32	450
55	Botswana	111	77	104	116	33	62	78	200
56	Egypt	104	54	86	78	38	71	35	320
57	Ecuador	107	95	99	104	53	5	56	170
58	Mongolia	104	. .	103	109	. .	. .	99	140
59	Nicaragua	108	. .	111	164	27	25	73	. .
60	Papua New Guinea	103	58	85	63	4	3	20	900
61	Dominican Rep.	107	96	101	. .	50	24	92	. .
62	Kenya	107	74	96	70	27	37	50	170^x
63	Honduras	107	93	101	129	41	16	90	220
64	South Africa	110	. .	. .	. .	48	. .	. .	83^x
Middle U5MR countries		**107**	**80**	**93**	**87**	**66**	**54**	**87**	**100**
65	Brazil	109	96	. .	131	66	62	95	200
66	El Salvador	110	92	101	100	47	19	50	. .
67	Iran, Islamic Rep. of	102	66	88	71	23^x	77	70	120
68	Algeria	103	66	85	87	36	27	15	140^x
69	Paraguay	107	96	96	107	48	54	66	300
70	Tunisia	103	76	87	78	50	40	68	50

		Life expectancy females as a % of males 1991	Adult literacy rate females as a % of males 1990	Enrolment ratios females as a % of males 1986-90		Contraceptive prevalence (%) 1980-92	Pregnant women immunized against tetanus 1990-91	% of births attended by trained health personnel 1983-91	Maternal mortality rate 1980-90
				primary school	secondary school				
71	Viet Nam	107	91	94	93	53	14	95	120
72	Syria	106	65	89	71	52	84	61	140
73	Jordan	106	79	101	98	35	47	87	48[x]
74	Lebanon	106	83	90	98	55[x]	. .	45	. .
75	Philippines	106	100	99	104	36	52	55	100
76	Venezuela	109	103	100	124	49[x]	. .	69	. .
77	Saudi Arabia	105	66	86	74	. .	62	90	90
78	Oman	106	. .	92	73	9	97	60	. .
79	Mexico	110	94	97	100	53	42	77	110
80	Romania	109	. .	99	110	58[x]	. .	100	150
81	Korea, Dem. Peo. Rep.	109	. .	94	100	. .	99	100	41
82	Thailand	108	94	99	88	66	76	71	71
83	USSR (former)	114	. .	101	. .	. .	. .	. .	21
84	Albania	109	. .	99	85	. .	. .	99	. .
85	Panama	106	100	96	113	58	27	96	60
86	United Arab Emirates	106	66	99	115	. .	. .	99	. .
87	Mauritius	110	. .	102	100	75	77	85	99
88	China	105	74	90	76	72	. .	94	95
89	Uruguay	109	99	99	112	. .	13	96	36
90	Argentina	110	99	107	113	74	. .	87	140
91	Trinidad and Tobago	107	. .	103	104	53	. .	98	110
92	Yugoslavia (former)	108	91	99	96	55[x]	. .	86	8
93	Bulgaria	109	. .	98	103	76[x]	. .	100	9
94	Chile	110	99	98	108	43[x]	. .	98	67
95	Sri Lanka	106	90	97	107	62	50	94	80
96	Colombia	109	98	102	102	66	40	94	200
Low U5MR countries		**109**	**. .**	**100**	**102**	**72**	**. .**	**97**	**12**
97	Malaysia	106	80	99	102	51	83	82	59
98	Jamaica	106	101	101	110	55	50	82	120
99	Costa Rica	106	100	98	102	70	68	93	36
100	Hungary	112	. .	101	103	73	. .	99	15
101	Poland	113	. .	100	104	75[x]	. .	100	11
102	Kuwait	106	87	98	94	. .	22	99	6
103	Cuba	105	98	95	112	70	88	90	39
104	Czechoslovakia	111	. .	101	107	95[x]	. .	100	10
105	Israel	105	. .	103	109	. .	. .	99	3
106	Portugal	110	92	94	119	66[x]	. .	90	10
107	USA	109	. .	99	101	74	. .	99	8
108	Greece	107	91	101	95	. .	. .	97	5
109	Ireland	108	. .	101	110	. .	. .	. .	2
110	Singapore	108	. .	98	104	74	. .	100	10
111	Belgium	109	. .	100	101	81	. .	100	3
112	Australia	109	. .	99	104	67[x]	. .	99	3
113	Italy	109	98	100	100	78[x]	. .	. .	4
114	New Zealand	109	. .	100	102	70[x]	. .	99	13
115	Korea, Rep. of	109	95	103	97	77	. .	89	26
116	Canada	109	. .	100	101	73	. .	99	5
117	Germany	109	. .	99	96	. .	. .	99	5
118	Denmark	108	. .	101	101	63[x]	. .	100	3
119	Switzerland	109	. .	. .	. .	71	. .	99	5
120	France	111	. .	97	108	79[x]	. .	94	9
121	United Kingdom	107	. .	101	104	72	. .	100	8
122	Austria	109	. .	99	102	71	. .	. .	8
123	Spain	108	96	98	111	59	. .	96	5
124	Hong Kong	107	. .	99	106	81	. .	100	6
125	Netherlands	109	. .	103	97	76	. .	100	10
126	Norway	109	. .	100	105	71[x]	. .	. .	3
127	Finland	111	. .	100	117	80[x]	. .	100	11
128	Japan	108	. .	100	103	64	. .	100	11
129	Sweden	108	. .	100	104	78	. .	100	5
Regional summaries									
Least developed countries		104	62	76	56	12	42	27	590
Developing countries		104	73	85	76	50	57	55	340
Developed countries		110	. .	100	103	72	. .	98	15
Sub-Saharan Africa		107	68	81	64	11	31	36	600
Middle East & North Africa		104	66	83	72	37	48	55	210
South Asia		101	54	73	56	38	73	30	490
East Asia & Pacific		106	77	92	82	66	53	81	160
Latin America & Caribbean		109	95	99	111	58	47	80	180

Countries listed in descending order of U5MR. Figures in coloured bands are totals or ***weighted*** *averages.*

TABLE 8: BASIC INDICATORS ON LESS POPULOUS COUNTRIES

		Under-5 mortality rate		Infant mortality rate (under 1)		Total population (thousands)	Annual no. of births (thousands)	Annual no. of under-5 deaths (thousands)	GNP per capita (US$)	Life expectancy at birth (years)	Total adult literacy rate	% of age-group enrolled in primary school (gross)	% of children immunized against measles
		1960	1991	1960	1991	1991	1991	1991	1990	1991	1985-90	1986-90	1990-91
1	Gambia	375	234	213	135	884	39.8	9.3	260	44	27	64	87
2	Equatorial Guinea	316	202	188	120	360	15.9	3.2	330	47	50	108^x	79
3	Djibouti	. .	161	186	115	453	21.2	3.4	1210^x	48	12	47	79
4	Comoros	248	133	165	92	564	27.6	3.7	480	55	48^x	75	87
5	Swaziland	233	113	157	76	771	29.0	3.3	820	57	55^x	104	80
6	Vanuatu	. .	89	. .	68	153	6.2	0.6	1060	65	53^x	84^x	66
7	Sao Tome and Principe	. .	89	. .	68	121	4.2	0.4	420	67	57^x	. .	68
8	Kiribati	. .	85	. .	56	72	2.4	0.2	760	55	96	91	63
9	Maldives	. .	81	158	58	220	8.6	0.7	440	63	95	87	97
10	Guyana	126	69	100	50	801	20.7	1.4	370	65	92^x	106	76
11	Cape Verde	164	61	110	44	373	13.4	0.8	890	67	37^x	115	76
12	Samoa	. .	59	. .	46	158	5.7	0.3	730	66	98	91^x	87
13	St.Christopher-Nevis	. .	43	. .	36	42	0.9	0.0	3330	70	90	. .	99
14	Tuvalu	. .	. .	. .	34^x	12	. .	. .	650^x	. .	90	. .	79
15	Suriname	96	37	70	30	430	11.4	0.4	3050	70	95	124	84
16	Grenada	. .	37	. .	30	91	2.4	0.1	2120	70	96^x	88^x	96
17	Montserrat	. .	35	. .	29	11	0.3	0.0	3330^x	71	97^x	100^x	99
18	Solomon Islands	. .	. .	120	28	331	12.5	. .	510	70	15	65^x	74
19	Qatar	239	35	145	28	440	10.4	0.4	15860	70	76	73	79
20	British Virgin Islands	. .	. .	. .	27^x	17	0.2^x	. .	8500^x	69^x	98^x	. .	84
21	Fed. States of Micronesia	. .	31	. .	26	107	3.7	0.1	980^x	71	63^x	101^x	12^x
22	Bahamas	. .	. .	51	25	260	5.1	. .	11420	72	70^x	. .	87^x
23	Fiji	97	30	71	25	732	18.0	0.5	1770	71	79^x	122	84
24	Turks and Caicos Islands	. .	. .	. .	25^x	12	0.2	. .	780^x	. .	98^x	. .	99
25	Belize	. .	29^x	. .	23^x	194	7.0	0.2	1970	68	93	90	74
26	Marshall Islands	. .	. .	. .	23^x	47	1.3^x	. .	. .	74^x	76^x	107	25^x
27	Palau	. .	. .	. .	23^x	15	0.5	. .	790^x	74^x	75	98^x	100
28	St Vincent & the Grenadines	. .	26	. .	22	108	2.5	0.1	1610	71	82	95^x	99
29	Tonga	. .	26	. .	22	97	3.1	0.1	1010	67	78	100^x	63^x
30	Antigua	. .	23	. .	19	66	1.3	0.0	4600	74	95	100	89
31	Saint Lucia	. .	22	. .	18	135	4.0	0.1	1900	72	82^x	95^x	82
32	Seychelles	. .	21	. .	17	71	1.6	0.0	4670	71	88	102^x	89
33	Dominica	. .	20	. .	16	72	1.7	0.0	1940	75	94^x	100	98
34	Cook Islands	. .	. .	. .	15^x	17	0.4^x	. .	1550^x	. .	75	100	100
35	Bahrain	208	18	130	14	518	13.7	0.2	6380	71	77	110	85
36	Malta	42	17	37	11	356	5.4	0.1	6610	76	88	108	80
37	Barbados	90	12	74	11	258	4.1	0.0	6540	75	98	110^x	87
38	Cyprus	36	11	30	10	709	12.4	0.1	8040	77	89^x	103	74
39	Brunei Darussalam	. .	10	63	9	264	6.4	0.1	20760^x	74	78^x	. .	99
40	Luxembourg	41	9	33	7	375	4.5	0.0	28730	75	. .	. .	80
41	Iceland	22	7	17	6	257	4.5	0.0	21400	78	. .	101	99

TABLE 9: NEWLY INDEPENDENT COUNTRIES

		Infant mortality rate (under 1) 1990	Total population (millions) 1990	Urban population (%) 1989-90	Population under 16 (%) 1989-90	Annual no. of births (thousands) 1990	% of one-year old children fully immunized (1989-91)		GDP per capita (US$) 1989	Life expectancy at birth (years) 1988-90	Total fertility rate 1989-90	Maternal mortality rate 1989
							polio	measles				
	USSR (former)											
1	Turkmenistan	94	3.7	47	43	126	84	68	3170	65	4.4	55
2	Tajikistan	72	5.3	33	44	203	90	89	2060	70	5.2	39
3	Uzbekistan	64	20.5	42	41	688	61	81	2430	69	4.1	43
4	Kyrgyzstan	54	4.4	38	27	127	72	91	2950	68	3.9	43
5	Kazakhstan	44	16.7	57	33	362	86	94	3890	69	2.9	53
6	Azerbaijan	44	7.2	54	33	180	93	91	3670	70	2.8	29
7	Armenia	35	3.3	68	30	79	96	92	4750	71	2.7	35
8	Moldova	33	4.4	47	24	77	92	95	4470	68	2.5	34
9	Georgia	32	5.5	55	25	93	80	74	4270	72	2.3	55
10	Ukraine	22	51.9	67	16	659	81	88	4720	71	2.0	33
11	Russian Federation	22	148.3	74	22	1987	75	79	6200	70	2.0	49
12	Belarus	20	10.3	66	22	143	90	95	6170	72	2.1	25
13	Estonia	14	1.6	72	24	23	70	86	6200	71	2.1	. .
14	Latvia	11	2.7	71	23	39	89	96	6360	71	2.0	. .
15	Lithuania	10	3.7	69	24	57	80	86	5830	72	2.0	. .
	Yugoslavia (former)											
16	Bosnia & Herzegovina	15	4.4	. .	. .	64	. .	. .	2290	71	1.7	25
17	Croatia	10	4.8	58	. .	56	. .	. .	4440	71	1.7	4
18	Slovenia	8	2.0	. .	. .	24	96	90	7630	72	1.6	4

Notes: 1. Within each of the two country groups, nations are listed in descending order of their 1990 infant mortality rate. 2. For countries in the USSR (former) group, GDP per capita in roubles have been converted to US dollars at the United Nations operational rate of exchange. 3. Only newly independent countries who are also members of the United Nations have been included.

Measuring human development

An introduction to table 10

If development in the 1990s is to assume a more human face, then there arises a corresponding need for a means of measuring human as well as economic progress. From UNICEF's point of view, in particular, there is a need for an agreed method of measuring the level of child well-being and its rate of change.

The under-five mortality rate (U5MR) is used in table 10 (next page) as the principle indicator of such progress.

U5MR has several advantages. First, it measures an end result of the development process rather than an 'input' such as school enrolment level, per capita calorie availability, or the number of doctors per thousand population - all of which are means to an end.

Second, the U5MR is known to be the result of a wide variety of inputs: the nutritional health and the health knowledge of mothers; the level of immunization and ORT use; the availability of maternal and child health services (including prenatal care); income and food availability in the family; the availability of clean water and safe sanitation; and the overall safety of the child's environment.

Third, U5MR is less susceptible than, say, per capita GNP to the fallacy of the average. This is because the natural scale does not allow the children of the rich to be one thousand times as likely to survive, even if the man-made scale does permit them to have one thousand times as much income. In other words, it is much more difficult for a wealthy minority to affect a nation's U5MR, and it therefore presents a more accurate, if far from perfect, picture of the health status of the majority of children (and of society as a whole).

For these reasons, the U5MR is chosen by UNICEF as its single most important indicator of the state of a nation's children. That is why the statistical annex lists the nations of the world not in ascending order of their per capita GNP but in descending order of their under five mortality rates.

The speed of progress in reducing the U5MR can be measured by calculating its average annual reduction rate (AARR). Unlike the comparison of absolute changes, the AARR reflects the fact that the limits to U5MR are approached only with increasing difficulty. As lower levels of under-five mortality are reached, for example, the same absolute reduction obviously represents a greater percentage of reduction. The AARR therefore shows a higher rate of progress for, say, a 10 point reduction if that reduction happens at a lower level of under-five mortality. (A fall in U5MR of 10 points from 100 to 90 represents a reduction of 10%, whereas the same 10-point fall from 20 to 10 represents a reduction of 50%).

When used in conjunction with GNP growth rates, the U5MR and its reduction rate can therefore give a picture of the progress being made by any country or region, and over any period of time, towards the satisfaction of some of the most essential of human needs.

As table 10 shows, there is no fixed relationship between the annual reduction rate of the U5MR and the annual rate of growth in per capita GNP. Such comparisons help to throw the emphasis on to the policies, priorities, and other factors which determine the ratio between economic and social progress.

Finally, the table gives the total fertility rate for each country and its average annual rate of reduction. It will be seen that many of the nations which have achieved significant reductions in U5MR have also achieved significant reductions in fertility.

TABLE 10: THE RATE OF PROGRESS

		Under-5 mortality rate						GNP per capita average annual growth rate (%)		Total fertility rate				
					average annual rate of reduction (%)								average annual rate of reduction (%)	
		1960	1980	1991	1960-80	1980-91	required** 1991-2000	1965-80	1980-90	1960	1980	1991	1960-80	1980-91
	Very high U5MR countries	**283**	**222**	**197**	**1.1**	**1.0**	**11.7**	**2.4**	**-1.8**	**6.6**	**6.8**	**6.6**	**-0.1**	**0.2**
1	Angola	345	261	292	1.4	-1.0	15.9	. .	6.1	6.4	6.9	7.2	-0.4	-0.4
2	Mozambique	331	269	292	1.0	-0.7	15.9	. .	-4.1	6.3	6.5	6.5	-0.2	0.0
3	Afghanistan	360	280	257	1.3	0.8	14.5	0.6	. .	6.9	7.1	6.9	-0.1	0.3
4	Sierra Leone	385	301	253	1.2	1.6	14.3	0.7	-1.5	6.2	6.5	6.5	-0.2	0.0
5	Guinea-Bissau	336	290	242	0.7	1.6	13.8	-2.7	1.7	5.1	5.7	5.8	-0.6	-0.2
6	Guinea	337	276	234	1.0	1.5	13.4	1.3	. .	7.0	7.0	7.0	0.0	0.0
7	Malawi	365	290	228	1.2	2.2	13.1	3.2	-0.1	6.9	7.6	7.6	-0.5	0.0
8	Mali	400	310	225	1.3	2.9	13.0	2.1[x]	1.2	7.1	7.1	7.1	0.0	0.0
9	Niger	321	259	218	1.1	1.6	12.6	-2.5	-4.5	7.1	7.1	7.1	0.0	0.0
10	Chad	325	254	213	1.2	1.6	12.4	-1.9	3.3	6.0	5.9	5.9	0.1	0.0
11	Ethiopia	294	260	212	0.6	1.9	12.3	0.4	-1.2	6.7	6.8	7.0	-0.1	-0.3
12	Somalia	294	246	211	0.9	1.4	12.3	-0.1	-1.8	7.0	7.0	7.0	0.0	0.0
13	Mauritania	321	249	209	1.3	1.6	12.2	-0.1	-1.8	6.5	6.5	6.5	0.0	0.0
14	Burkina Faso	363	254	206	1.8	1.9	12.0	1.7	1.4	6.4	6.5	6.5	-0.1	0.0
15	Bhutan	324	249	205	1.3	1.8	11.9	. .	7.4	6.0	5.9	5.9	0.1	0.0
16	Zambia	220	160	200	1.6	-2.0	11.7	-1.2	-2.9	6.6	7.1	6.5	-0.4	0.8
17	Liberia	310	244	200	1.2	1.8	11.7	0.5	5.2[x]	6.6	6.8	6.8	-0.1	0.0
18	Uganda	223	190	190	0.8	0.0	11.1	-2.2	0.8	6.9	7.0	7.3	-0.1	-0.4
19	Rwanda	255	219	189	0.8	1.3	11.0	1.6	-2.2	7.5	8.5	8.5	-0.6	0.0
20	Nigeria	212	196	188	0.4	0.4	11.0	4.2	-3.0	6.8	6.9	6.6	-0.1	0.4
21	Cambodia	217	330	188	-2.1	5.1	11.0	. .	. .	6.3	4.5	4.5	1.7	0.0
22	Senegal	299	232	182	1.3	2.2	10.6	-0.5	0.0	7.0	6.9	6.2	0.1	1.0
23	Yemen	378	236	182	2.4	2.4	10.6	. .	. .	7.5	7.7	7.3	-0.1	0.5
24	Burundi	260	207	181	1.1	1.2	10.6	2.4	1.3	6.8	6.8	6.8	0.0	0.0
25	Zaire	300	203	180	2.0	1.1	10.5	-1.3	-1.5	6.0	6.6	6.7	-0.5	-0.1
26	Central African Rep.	294	202	180	1.9	1.0	10.5	0.8	-1.3	5.6	6.0	6.2	-0.3	-0.3
27	Tanzania	249	202	178	1.0	1.1	10.4	0.8	-0.7	6.8	6.8	6.8	0.0	0.0
28	Madagascar	364	216	173	2.6	2.0	10.1	-0.4	-2.3	6.6	6.6	6.6	0.0	0.0
29	Sudan	292	210	169	1.6	2.0	9.8	0.8	1.8[x]	6.7	6.6	6.2	0.1	0.6
30	Gabon	287	194	161	2.0	1.7	9.3	5.6	-2.6	4.1	4.4	5.2	-0.4	-1.5
31	Benin	310	176	149	2.8	1.5	8.4	-0.3	-1.0	6.9	7.1	7.1	-0.1	0.0
32	Lao, Peo. Dem.	233	190	148	1.0	2.3	8.3	. .	0.7	6.2	6.7	6.7	-0.4	0.0
33	Nepal	298	185	147	2.4	2.1	8.2	. .	1.8	5.8	6.4	5.6	-0.5	1.2
34	Togo	305	184	144	2.5	2.2	8.0	1.7	-1.7	6.6	6.6	6.6	0.0	0.0
35	Iraq	171	83	143	3.6	-4.9	7.9	. .	. .	7.2	6.5	5.8	0.5	1.0
	High U5MR countries	**231**	**165**	**116**	**1.6**	**3.1**	**6.2**	**2.6**	**1.8**	**6.1**	**5.1**	**4.2**	**0.9**	**1.8**
36	Lesotho	210	165	137	1.2	1.7	7.5	6.8	-0.9	5.8	5.6	4.8	0.2	1.4
37	Haiti	270	195	137	1.6	3.2	7.5	0.9	-2.3	6.3	5.3	4.9	0.9	0.7
38	Ghana	224	166	137	1.5	1.7	7.5	-0.8	-0.6	6.9	6.5	6.1	0.3	0.6
39	Pakistan	221	152	134	1.9	1.1	7.2	1.8	2.9	6.9	7.0	6.3	-0.1	1.0
40	Bangladesh	247	211	133	0.8	4.2	7.1	-0.3	1.0	6.7	6.4	4.8	0.2	2.6
41	Côte d'Ivoire	300	180	127	2.6	3.2	6.6	2.8	-3.7	7.2	7.4	7.4	-0.1	0.0
42	India	236	177	126	1.4	3.1	6.5	1.5	3.2	5.9	4.8	4.0	1.0	1.7
43	Cameroon	270	170	126	2.3	2.7	6.5	2.4	-0.3	5.8	6.4	5.8	-0.5	0.9
44	Bolivia	282	180	126	2.2	3.2	6.5	1.7	-2.6	6.7	5.8	4.7	0.7	1.9
45	Namibia	248	161	120	2.2	2.7	6.0	. .	. .	6.0	6.0	6.0	0.0	0.0
46	Myanmar	237	146	117	2.4	2.0	5.7	1.6	. .	6.0	5.1	4.3	0.8	1.6
47	Congo	220	125	110	2.8	1.2	5.0	2.7	-0.2	5.9	6.3	6.3	-0.3	0.0
48	Libyan Arab Jamahiriya	269	150	108	2.9	3.0	4.8	0.0	-9.2	7.1	7.3	6.5	-0.1	1.1
49	Peru	240	145	97	2.5	3.7	4.5	0.8	-2.0	6.9	5.0	3.7	1.6	2.7
50	Guatemala	220	140	92	2.3	3.8	4.5	3.0	-2.1	6.9	6.3	5.5	0.5	1.2
51	Morocco	265	145	91	3.0	4.2	4.5	2.7	1.6	7.2	5.7	4.5	1.2	2.1
52	Turkey	216	141	89	2.1	4.2	4.5	3.6	3.0	6.3	4.3	3.6	1.9	1.6
53	Zimbabwe	181	125	88	1.9	3.2	4.5	1.7	-0.8	7.5	6.4	5.5	0.8	1.4
54	Indonesia	215	131	86	2.5	3.8	4.5	5.2	4.1	5.5	4.4	3.2	1.1	2.9
55	Botswana	169	108	85	2.2	2.2	4.5	9.9	6.3	6.8	6.8	5.2	0.0	2.4
56	Egypt	260	179	85	1.9	6.8	4.5	2.8	2.1	7.0	5.2	4.2	1.5	1.9
57	Ecuador	184	107	82	2.7	2.4	4.5	5.4	-0.8	6.9	5.1	3.8	1.5	2.7
58	Mongolia	185	112	82	2.5	2.8	4.5	. .	. .	6.0	5.4	4.7	0.5	1.3
59	Nicaragua	209	143	81	1.9	5.2	4.5	-0.7	4.7[x]	7.4	6.2	5.2	0.9	1.6
60	Papua New Guinea	248	95	79	4.8	1.7	4.5	. .	-0.5	6.3	5.7	5.0	0.5	1.2
61	Dominican Rep.	200	102	76	3.4	2.7	4.5	3.8	-0.4	7.4	4.5	3.5	2.5	2.3
62	Kenya	202	112	75	2.9	3.6	4.5	3.1	0.3	8.0	7.8	6.4	0.1	1.8
63	Honduras	230	120	73	3.3	4.5	4.5	1.1	-1.2	7.3	6.4	5.1	0.7	2.1
64	South Africa	126	91	72	1.6	2.1	4.5	3.2	-0.9	6.5	4.9	4.2	1.4	1.4
	Middle U5MR countries	**174**	**69**	**36**	**4.4**	**5.8**	**4.5**	**4.2**	**1.4**	**5.1**	**3.2**	**2.7**	**2.4**	**1.7**
65	Brazil	179	93	67	3.3	3.0	4.5	6.3	0.6	6.2	4.0	2.9	2.2	2.9
66	El Salvador	210	120	67	2.8	5.3	4.5	1.5	-0.6	6.8	5.4	4.2	1.2	2.3
67	Iran, Islamic Rep. of	233	126	62	3.1	6.4	4.5	2.9	-0.8	7.2	6.5	6.1	0.5	0.6
68	Algeria	243	145	61	2.6	7.9	4.5	4.2	-0.3	7.3	6.8	5.0	0.4	2.8
69	Paraguay	103	70	59	1.9	1.6	4.5	4.1	-1.3	6.8	4.9	4.4	1.6	1.0
70	Tunisia	254	103	58	4.5	5.2	4.5	4.7	0.9	7.1	5.3	3.6	1.5	3.5

		Under-5 mortality rate						GNP per capita average annual growth rate (%)		Total fertility rate				
					average annual rate of reduction (%)								average annual rate of reduction (%)	
		1960	1980	1991	1960-80	1980-91	required** 1991-2000	1965-80	1980-90	1960	1980	1991	1960-80	1980-91
71	Viet Nam	219	105	52	3.7	6.4	4.5	. .	. .	6.0	5.1	4.0	0.9	2.2
72	Syria	217	86	47	4.6	5.5	4.5	5.1	-2.1	7.3	7.4	6.3	-0.1	1.5
73	Jordan	180	75	46	4.4	4.4	4.5	5.8[x]	-3.9	7.7	7.1	5.8	0.4	1.8
74	Lebanon	91	62	46	1.9	2.7	4.5	. .	. .	6.3	4.0	3.2	2.3	2.0
75	Philippines	128	79	46	2.4	4.9	4.5	3.2	-1.5	6.8	4.9	4.0	1.6	1.8
76	Venezuela	114	50	43	4.1	1.4	4.5	2.3	-2.0	6.5	4.2	3.2	2.2	2.5
77	Saudi Arabia	292	90	43	5.9	6.7	4.5	4.0[x]	-5.6	7.2	7.3	6.5	-0.1	1.1
78	Oman	378	100	42	6.6	7.9	4.5	9.0	7.1	7.2	7.2	6.8	0.0	0.5
79	Mexico	138	81	37	2.7	7.1	4.5	3.6	-0.9	6.8	4.7	3.3	1.8	3.2
80	Romania	82	36	34	4.1	0.5	4.5	. .	1.1	2.3	2.4	2.2	-0.2	0.8
81	Korea, Dem. Peo. Rep.	120	43	34	5.1	2.1	4.5	. .	. .	5.8	3.1	2.4	3.1	2.3
82	Thailand	146	61	33	4.4	5.6	4.5	4.4	5.6	6.4	3.6	2.3	2.9	4.1
83	USSR (former)	53	37	31	1.8	1.6	4.5	. .	. .	2.7	2.3	2.3	0.8	0.0
84	Albania	151	57	31	4.9	5.5	4.5	. .	. .	5.9	3.8	2.8	2.2	2.8
85	Panama	105	42	30	4.6	3.1	4.5	2.8	-2.0	5.9	3.8	3.0	2.2	2.1
86	United Arab Emirates	239	43	29	8.6	3.6	4.5	. .	-7.2	6.9	5.4	4.6	1.2	1.5
87	Mauritius	104	42	28	4.5	3.7	4.5	3.7	5.4	5.9	2.8	2.0	3.7	3.1
88	China	205	63	27	5.9	7.7	4.5	4.1	7.9	5.7	2.7	2.3	3.7	1.5
89	Uruguay	57	43	24	1.4	5.3	4.5	2.5	-0.9	2.9	2.7	2.4	0.4	1.1
90	Argentina	70	41	24	2.7	4.9	4.5	1.7	-1.8	3.1	3.3	2.8	-0.3	1.5
91	Trinidad and Tobago	69	40	23	2.7	5.0	4.5	3.1	-6.0	5.2	3.3	2.8	2.3	1.5
92	Yugoslavia (former)	113	37	22	5.6	4.7	4.5	5.2	-0.9	2.8	2.1	1.9	1.4	0.9
93	Bulgaria	70	25	21	5.1	1.6	4.5	. .	2.3	2.2	2.1	1.9	0.2	0.9
94	Chile	142	44	21	5.9	6.7	4.5	0.0	1.1	5.3	2.8	2.7	3.2	0.3
95	Sri Lanka	130	52	21	4.6	8.2	4.5	2.8	2.4	5.3	3.5	2.5	2.1	3.1
96	Colombia	130	59	21	3.9	9.4	4.5	3.7	1.1	6.8	3.8	2.7	2.9	3.1
Low U5MR countries		**48**	**17**	**11**	**5.0**	**4.1**	**4.5**	**. .**	**2.5**	**3.0**	**1.9**	**1.8**	**2.2**	**0.4**
97	Malaysia	105	42	20	4.6	6.7	4.5	4.7	2.5	6.8	4.2	3.7	2.4	1.2
98	Jamaica	89	28	19	5.8	3.5	4.5	-0.1	-0.4	5.4	3.8	2.5	1.8	3.8
99	Costa Rica	122	31	18	6.9	4.9	4.5	3.3	0.6	7.0	3.7	3.2	3.2	1.3
100	Hungary	57	26	17	3.9	3.9	4.5	5.1	1.5	2.0	2.0	1.8	0.0	1.0
101	Poland	70	24	17	5.1	3.1	4.5	. .	1.2	3.0	2.3	2.1	1.3	0.8
102	Kuwait	128	35	17	6.5	6.6	4.5	0.6[x]	-2.2	7.3	5.4	3.8	1.5	3.2
103	Cuba	91	24	14	6.7	4.9	4.5	. .	. .	4.2	2.0	1.9	3.7	0.5
104	Czechoslovakia	33	20	13	2.5	3.9	4.5	. .	1.3	2.5	2.2	2.0	0.6	0.9
105	Israel	39	19	12	3.6	4.2	4.5	3.7	1.5	3.9	3.3	2.9	0.8	1.2
106	Portugal	112	31	12	6.4	8.6	4.5	4.6	2.4	3.1	2.2	1.5	1.7	3.5
107	USA	30	15	11	3.5	2.8	4.5	1.8	2.2	3.5	1.8	2.0	3.3	-1.0
108	Greece	64	23	11	5.1	6.7	4.5	4.8	1.5	2.2	2.1	1.5	0.2	3.1
109	Ireland	36	14	10	4.7	3.1	4.5	2.8	1.1	3.8	3.2	2.2	0.9	3.4
110	Singapore	50	15	10	6.0	3.7	4.5	8.3	5.7	5.5	1.8	1.7	5.6	0.5
111	Belgium	35	15	10	4.2	3.7	4.5	3.6	1.2	2.6	1.7	1.6	2.1	0.6
112	Australia	24	13	10	3.1	2.4	4.5	2.2	1.7	3.3	2.0	1.9	2.5	0.5
113	Italy	50	17	10	5.4	4.8	4.5	3.2	2.2	2.4	1.7	1.3	1.7	2.4
114	New Zealand	26	16	10	2.4	4.3	4.5	1.7	0.6	3.9	2.1	2.1	3.1	0.0
115	Korea, Rep. of	126	19	10	9.5	5.8	4.5	7.3	8.9	5.7	2.6	1.7	3.9	3.9
116	Canada	33	13	9	4.7	3.3	4.5	3.3	2.4	3.8	1.7	1.8	4.0	-0.5
117	Germany	40	16	9	4.6	5.2	4.5	3.0[x]	2.2[x]	2.4	1.5	1.5	2.4	0.0
118	Denmark	25	10	9	4.6	1.0	4.5	2.2	2.1	2.6	1.6	1.7	2.4	-0.6
119	Switzerland	27	11	9	4.5	1.8	4.5	1.5	1.7	2.4	1.5	1.6	2.4	-0.6
120	France	34	13	9	4.8	3.3	4.5	3.7	1.7	2.8	1.9	1.8	1.9	0.5
121	United Kingdom	27	14	9	3.3	4.0	4.5	2.0	2.5	2.7	1.8	1.9	2.0	-0.5
122	Austria	43	17	9	4.6	5.8	4.5	4.0	2.0	2.7	1.6	1.5	2.6	0.6
123	Spain	57	16	9	6.4	5.2	4.5	4.1	2.7	2.8	2.2	1.4	1.2	4.1
124	Hong Kong	64	14	8	7.6	5.1	4.5	6.2	5.5	5.0	2.1	1.4	4.3	3.7
125	Netherlands	22	11	8	3.5	2.9	4.5	2.7	1.4	3.1	1.5	1.7	3.6	-1.1
126	Norway	23	11	8	3.7	2.9	4.5	3.6	2.7	2.9	1.7	1.9	2.7	-1.0
127	Finland	28	9	7	5.7	2.3	4.5	3.6	3.1	2.7	1.7	1.8	2.3	-0.5
128	Japan	40	11	6	6.5	5.5	4.5	5.1	3.5	2.0	1.8	1.7	0.5	0.5
129	Sweden	20	9	5	4.0	5.3	4.5	2.0	1.8	2.3	1.6	2.0	1.8	-2.0
Regional summaries														
Least developed countries		286	222	180	1.2	1.9	10.8	-0.1	0.1	6.6	6.5	6.0	0.0	0.7
Developing countries		217	138	101	2.1	2.8	8.0	3.7	2.2	6.0	4.4	3.7	1.4	1.5
Developed countries		45	23	17	3.3	2.5	4.5	. .	2.4	2.8	2.0	1.9	1.7	0.1
Sub-Saharan Africa		261	203	180	1.2	1.2	11.2	2.5	-0.9	6.7	6.7	6.5	0.0	0.3
Middle East & North Africa		246	145	90	2.6	3.7	6.4	3.8	-1.4	7.0	5.9	5.0	0.8	1.4
South Asia		238	179	131	1.4	2.8	7.1	1.5	3.0	6.1	5.2	4.4	0.7	1.7
East Asia & Pacific		198	80	42	4.2	5.5	4.9	. .	6.8	5.8	3.2	2.6	2.8	1.9
Latin America & Caribbean		161	89	57	3.0	4.0	4.7	4.1	-0.3	6.0	4.2	3.2	1.8	2.5

*** The average annual reduction rate required to achieve an under-five mortality rate in all countries of 70 per 1000 live births or of two thirds the 1990 rate, whichever is the less. Countries listed in descending order of U5MR. Figures in coloured bands are totals or* ***weighted*** *averages.*

Country groupings

Developing countries:

Afghanistan
Algeria
Angola
Argentina
Bangladesh
Benin
Bhutan
Bolivia
Botswana
Brazil
Burkina Faso
Burundi
Cambodia
Cameroon
Central African Rep.
Chad
Chile
China
Colombia
Congo
Costa Rica
Côte d'Ivoire
Cuba
Dominican Rep.
Ecuador
Egypt
El Salvador
Ethiopia
Gabon
Ghana
Guatemala
Guinea
Guinea-Bissau
Haiti
Honduras
Hong Kong
India
Indonesia
Iran, Islamic Rep. of
Iraq
Jamaica
Jordan
Kenya
Korea, Dem. Peo. Rep.
Korea, Rep. of
Kuwait
Lao, Peo. Dem. Rep.
Lebanon
Lesotho
Liberia
Libyan Arab Jamahiriya
Madagascar
Malawi
Malaysia
Mali
Mauritania
Mauritius
Mexico
Mongolia
Morocco
Mozambique
Myanmar
Namibia
Nepal
Nicaragua
Niger
Nigeria
Oman
Pakistan
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Rwanda
Saudi Arabia
Senegal
Sierra Leone
Singapore
Somalia
South Africa
Sri Lanka
Sudan
Syria
Tanzania
Thailand
Togo
Trinidad and Tobago
Tunisia
Turkey
Uganda
United Arab Emirates
Uruguay
Venezuela
Viet Nam
Yemen
Zaire
Zambia
Zimbabwe

Sub-Saharan Africa:

Angola
Benin
Botswana
Burkina Faso
Burundi
Cameroon
Central African Rep.
Chad
Congo
Côte d'Ivoire
Ethiopia
Gabon
Ghana
Guinea
Guinea-Bissau
Kenya
Lesotho
Liberia
Madagascar
Malawi
Mali
Mauritania
Mauritius
Mozambique
Namibia
Niger
Nigeria
Rwanda
Senegal
Sierra Leone
Somalia
South Africa
Tanzania
Togo
Uganda
Zaire
Zambia
Zimbabwe

Middle East & North Africa:

Algeria
Egypt
Iran, Islamic Rep. of
Iraq
Jordan
Kuwait
Lebanon
Libyan Arab Jamahiriya
Morocco
Oman
Saudi Arabia
Sudan
Syria
Tunisia
Turkey
United Arab Emirates
Yemen

South Asia:

Afghanistan
Bangladesh
Bhutan
India
Nepal
Pakistan
Sri Lanka

East Asia & Pacific:

Cambodia
China
Hong Kong
Indonesia
Korea, Dem. Peo. Rep.
Korea, Rep. of
Lao, Peo. Dem. Rep.
Malaysia
Mongolia
Myanmar
Papua New Guinea
Philippines
Singapore
Thailand
Viet Nam

Latin America & Caribbean:

Argentina
Bolivia
Brazil
Chile
Colombia
Costa Rica
Cuba
Dominican Rep.
Ecuador
El Salvador
Guatemala
Haiti
Honduras
Jamaica
Mexico
Nicaragua
Panama
Paraguay
Peru
Trinidad and Tobago
Uruguay
Venezuela

Least developed countries:

Afghanistan
Bangladesh
Benin
Bhutan
Botswana
Burkina Faso
Burundi
Cambodia
Chad
Ethiopia
Guinea
Guinea-Bissau
Haiti
Lao, Peo. Dem. Rep.
Lesotho
Liberia
Madagascar
Malawi
Mali
Mauritania
Mozambique
Myanmar
Nepal
Niger
Rwanda
Sierra Leone
Somalia
Sudan
Tanzania
Togo
Uganda
Yemen
Zaire
Zambia

Developed countries:

Albania
Australia
Austria
Belgium
Bulgaria
Canada
Czechoslovakia
Denmark
Finland
France
Germany
Greece
Hungary
Ireland
Israel
Italy
Japan
Netherlands
New Zealand
Norway
Poland
Portugal
Romania
Spain
Sweden
Switzerland
USA
USSR (former)
United Kingdom
Yugoslavia (former)

Definitions

Under-five mortality rate:	number of deaths of children under five years of age per 1,000 live births More specifically, this is the probability of dying between birth and exactly five years of age.
Infant mortality rate:	number of deaths of infants under one year of age per 1,000 live births More specifically, this is the probability of dying between birth and exactly one year of age.
GNP:	gross national product Annual GNPs per capita are expressed in current United States dollars. GNP per capita growth rates are average annual growth rates that have been computed by fitting trend lines to the logarithmic values of GNP per capita at constant market prices for each year of the time period.
Life expectancy at birth:	the number of years newborn children would live if subject to the mortality risks prevailing for the cross-section of population at the time of their birth.
Adult literacy rate:	percentage of persons aged 15 and over who can read and write.
Primary and secondary enrolment ratios:	The gross enrolment ratio is the total number of children enrolled in a schooling level - whether or not they belong in the relevant age group for that level - expressed as a percentage of the total number of children in the relevant age group for that level The net enrolment ratio is the total number of children enrolled in a schooling level who belong in the relevant age group, expressed as a percentage of the total number in that age-group.
Income share:	percentage of private income received by the highest 20% and lowest 40% of households.
Low birth weight:	Less than 2,500 grams.
Underweight:	moderate and severe - below minus two standard deviations from median weight for age of reference population; severe - below minus three standard deviations from median weight for age of reference population.
Wasting:	moderate and severe - below minus two standard deviations from median weight for height of reference population.
Stunting:	moderate and severe - below minus two standard deviations from median height for age of reference population.
Access to health services:	percentage of the population that can reach appropriate local health services by the local means of transport in no more than one hour
DPT:	diphtheria, pertussis (whooping cough) and tetanus.
ORT use:	percentage of all cases of diarrhoea in children under five years of age treated with oral rehydration salts or an appropriate household solution.
Children reaching final grade of primary school:	percentage of the children entering the first grade of primary school who eventually reach the final grade.
Crude death rate:	annual number of deaths per 1,000 population.
Crude birth rate:	annual number of births per 1,000 population.
Total fertility rate:	the number of children that would be born per woman, if she were to live to the end of her child-bearing years and bear children at each age in accordance with prevailing age-specific fertility rates.
Urban population:	percentage of population living in urban areas as defined according to the national definition used in the most recent population census.
Absolute poverty level:	the income level below which a minimum nutritionally adequate diet plus essential non-food requirements is not affordable.
ODA:	official development assistance.
Debt service:	the sum of interest payments and repayments of principal on external public and publicly guaranteed long-term debts.
Contraceptive prevalence:	percentage of married women aged 15-49 currently using contraception.
Births attended:	percentage of births attended by physicians, nurses, midwives, trained primary health care workers or trained traditional birth attendants.
Maternal mortality rate:	annual number of deaths of women from pregnancy related causes per 100,000 live births.
GDP:	gross domestic product.

Main sources

Under-five and infant mortality:	United Nations Population Division, UNICEF, United Nations Statistical Division, World Bank and US Bureau of the Census (table 9).
Total population:	United Nations Population Division.
Births:	United Nations Population Division, United Nations Statistical Division and World Bank.
Under-five deaths:	United Nations Population Division and UNICEF.
GNP per capita:	World Bank.
Life expectancy:	United Nations Population Division.
Adult literacy:	United Nations Educational, Scientific and Cultural Organization (UNESCO).
School enrolment and completion:	United Nations Educational, Scientific and Cultural Organization (UNESCO).
Household income:	World Bank.
Low birth weight:	World Health Organization (WHO).
Breastfeeding:	Demographic Health Surveys, IRD, and World Health Organization (WHO).
Underweight, wasting and stunting:	World Health Organization (WHO) and Demographic and Health Surveys, Institute for Resource Development of Macro Systems, (IRD).
Food production and calorie intake:	Food and Agricultural Organization of the United Nations (FAO).
Income spent on food:	World Bank.
Access to drinking water and sanitation facilities:	World Health Organization (WHO) and UNICEF.
Access to health services:	UNICEF.
Immunization:	World Health Organization (WHO) and UNICEF.
ORT use:	World Health Organization (WHO).
Radio and television:	United Nations Educational, Scientific and Cultural Organization (UNESCO).
Child population:	United Nations Population Division.
Crude death and birth rates:	United Nations Population Division.
Fertility:	United Nations Population Division.
Urban population:	United Nations Population Division.
Inflation and absolute poverty level:	World Bank.
Expenditure on health, education and defence:	World Bank and International Monetary Fund (IMF).
ODA:	Organisation for Economic Co-operation and Development (OECD).
Debt service:	World Bank.
Contraceptive prevalence:	United Nations Population Division, Rockefeller Foundation, and Demographic and Health Surveys, IRD.
Births attended:	World Health Organization (WHO).
Maternal mortality:	World Health Organization (WHO).
GDP per capita:	United Nations Statistical Division.

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THE STATE OF THE WORLD'S CHILDREN 1993

Despite the problems of the post cold war world, this year's *State of the World's Children* report argues that it is possible - within a decade - to bring to an end the age-old evils of child malnutrition, preventable disease, and widespread illiteracy.

As an indication of how close that goal might be, UNICEF puts the financial cost at about $25 billion a year. With today's low-cost strategies, says the report, such a sum could bring under control the major childhood diseases, halve the rate of child malnutrition, provide clean water and safe sanitation to all communities, make family planning services universally available, and provide almost every child with at least a basic education.

If so much could be done for so many and for so little, then why is it not done?

The extent of present neglect, says UNICEF, is a scandal of which the public is largely unaware. On average, the governments of the developing world are devoting little more than 10% of their budgets to helping the poor meet their needs for nutrition and health care, water and sanitation, education and family planning. Similarly, less than 10% of all international aid for development is devoted to directly meeting these most obvious of human needs.

But there is now an accumulation of reasons, says UNICEF, for believing that the age of neglect may be giving way to an age of concern.

The most dramatic indication is the achievement of the 80% immunization target in the developing world - saving 3 million children's lives each year.

Other equally powerful strategies are now tried and tested, available and affordable. Specific goals which reflect this new potential were agreed on at the 1990 *World Summit for Children* and the commitment to achieving these goals by the end of the decade now bears the signatures of more Presidents and Prime Ministers than any other document in history. Detailed plans have already been drawn up in over 50 nations and are in preparation in 80 more. Meanwhile the broader context of political, economic, and demographic change is probably as favourable at this time as it is ever likely to be.

What is required now, says UNICEF, is a worldwide mobilization of public and political support for the cause of meeting basic human needs. Only through massive popular concern, and through the practical and political energies of literally millions of people and thousands of organizations, will the commitments that have been made be given a priority in national life. And only by such means will a new age of concern be born.

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